
New Hampshire Insurance Department

Preliminary Report of the 2014 Medical Cost Drivers

Based on Annual Hearing and Supplemental Report Data

November 2015

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1. Overview of New Hampshire Health Insurance Market in 2014

January 1, 2014 marked the implementation of many major health care reform provisions under the Affordable Care Act (ACA). Some of the most substantive changes as a result of the ACA that are discussed in this report include the introduction of the Health Insurance Marketplace¹ in New Hampshire, new rating and benefit requirements in the Individual and Small Group Markets, new product offerings in the Individual Market, and the introduction of risk adjustment, reinsurance and risk corridor programs.

The uninsured rate for all New Hampshire residents has decreased from 11% in 2013 to 9% in 2014. The number of uninsured has decreased from 140,000 to 120,000 from 2013 to 2014.

- Given the timing of the data, the chart below does not fully reflect the impact of the Medicaid expanded health care coverage program, also known as the New Hampshire Health Protection Program (NHHPP), which started August 15, 2014. Medicaid enrollment from the New Hampshire Department of Health and Human Services (DHHS) shows that compared to end of 2013, the Medicaid population increased by 42,000 members as of the end of December 2014 and by a cumulative 55,000 members as of the end of September 2015.²
- The most recent estimates show that, as of 2015, 94,000 New Hampshire residents remain uninsured which translates to approximately 7% of total New Hampshire residents in 2015. Of these remaining uninsured, approximately 57% are estimated to be eligible for Medicaid or eligible for premium tax credits through the exchange.³

¹ The Health Insurance Marketplace is referred to throughout this document as the “exchange.”

² The cumulative increase in Medicaid enrollment as of September 2015 includes approximately 43,000 enrollees in the New Hampshire Health Protection Program (NHHPP). Membership data provided by NH DHHS.

³ Kaiser Family Foundation: New Estimates of Eligibility for ACA Coverage among the Uninsured, October 2015.
<http://kff.org/uninsured/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/>

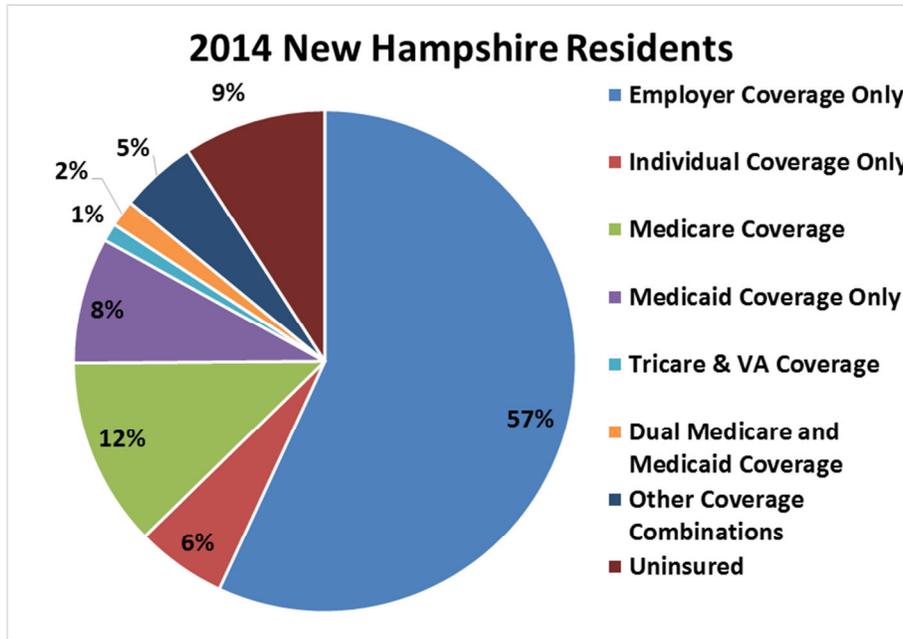


Figure 1: New Hampshire Residents by Health Insurance Status in 2014⁴

In 2014 there are approximately 494,000 New Hampshire Commercial situs⁵ members and 206,000⁶ New Hampshire Commercial non-situs members. There are an additional 48,000 New Hampshire Federal Employees Health Benefits Program (FEHBP) members⁷.

- Data are collected from two data requests: The Supplemental Report (SR)⁸ and Annual Hearing Carrier Questionnaire (AH)⁹. Each serves a different purpose and captures a slightly different population.
 - For the SR, we collect data from all carriers in the market, except those that request an exemption due to meeting the *de minimis* requirements¹⁰. For CY 2014, we estimate that for the NH situs population, we collected data that represents approximately 94% of the covered lives in the Individual Market.¹¹ For the Small Group, Large Group and Self-Insured markets we

⁴ U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates

⁵ "Situs" of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy. Carriers are instructed to apply the same consideration when determining situs for this report as they do when preparing the NAIC Supplemental Health Care Exhibit. TPAs shall determine situs of their contracts in a similar manner. NH situs members may not be residents of NH. NH non-situs members include NH residents whose employer is not situated in NH. The Supplemental Report collects more detailed data for NH situs members than for non-NH situs members.

⁶ Based on the carriers surveyed. This does not include data for Anthem companies not licensed in NH with membership residing in NH. This represents about 40,000 members.

⁷ Anthem estimate of New Hampshire membership in all carrier plans combined.

⁸ Starting this year, the data collected for CY 2014 reported by carriers in 2015 in the Supplemental Report data response will be referred to as Supplemental Report data 2015.

⁹ Consistent with prior years, the data collected primarily for 2014 and early 2015 in the Annual Hearing data request will be referred to as Annual Hearing data 2015.

¹⁰ http://www.nh.gov/insurance/media/bulletins/2015/documents/ins_15-010-ab.pdf

¹¹ The remaining 6% represents data primarily from Assurant (Time) and MVP, which both met the *de minimis* requirements.

estimate that we collect data on approximately 99% of the market. Data is also collected for the Federal Employees Health Benefits Program (FEHBP) and non-New Hampshire situs membership. The focus of the SR is detailed benefit information along with membership, cost sharing, claims and premium.

- For the AH, we collect data from the three largest carriers for CY 2014 (Anthem/Matthew Thornton Health Plan, Harvard Pilgrim Health Care, and CIGNA), and added Community Health Options¹² and Minuteman Health for early 2015 data. For CY 2014, data for these three largest carriers cover percentages of the market very similar to those for the SR – that is, approximately 94% of the Individual Market and approximately 99% for the Small Group and Large Group Markets. The focus of the AH is more detailed claims trend, rating assumptions and demographic information.
- The information from these two separate data requests are integrated into one set of findings in this report.

Consistent with prior years, three carriers dominate the New Hampshire Commercial insurance market in CY 2014.

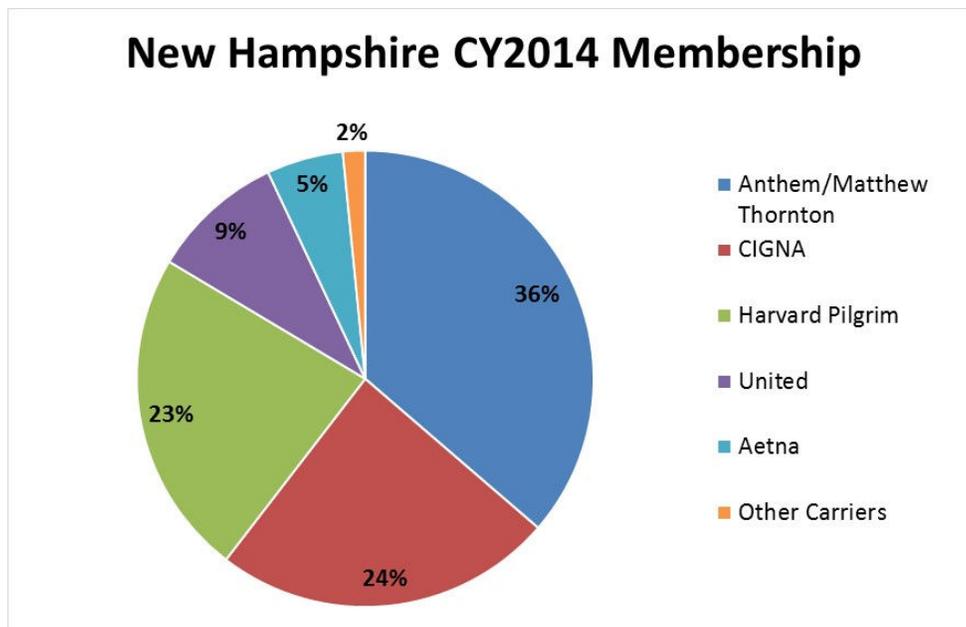


Figure 2: Distribution by Carrier of New Hampshire Commercial Situs and Non-Situs CY 2014¹³

As of April 2015, approximately 47% of the New Hampshire Commercial Situs Market members are fully-insured.¹⁴

¹² Formerly Maine Community Health Options.

¹³ NHID Supplemental Report data 2015; Excludes FEHBP.

¹⁴ NHID Annual Hearing data 2013, 2014 and 2015; Excludes FEHBP; Includes Community Health Options and Minuteman Health.

- In CY 2013 the percentage of fully-insured members was approximately 49%; therefore there has been a slight decrease in the fully-insured distribution from CY 2013 to April 2015.
- This shift is driven by movement of large group accounts from fully-insured to self-insured, partially offset by an increase in Individual Market (fully-insured) membership.

Between December 2013 and April 2015, the fully-insured markets grew by approximately 7,000 members and there have been shifts in distribution by market segment.

- The overall fully-insured market in New Hampshire grew from approximately 228,000 members as of December 2013 to 235,000 members as of April 2015.¹⁵
- The Individual Market has grown in its share of the fully-insured market from 16% as of December 2013 to 27% as of April 2015, or from 37,000 to 65,000 members. Anthem (including Matthew Thornton Health Plan), Harvard Pilgrim, Minuteman Health and Community Health Options all gained market share in the Individual Market during this time.¹⁶
- As of April 2015, 8% of members in the Individual Market are grandfathered¹⁷ and 9% are in ACA transitional¹⁸ products.
- The Small Group Market share has decreased from 38% in December 2013 to 32% in April 2015, or from 86,000 members to 75,000 members. A portion of this decrease is a result of the ACA changing the Small Group definition as of January 1, 2014 to exclude sole proprietors (who are now part of the Individual Market). In addition, the definition of how employees are counted changed as of January 1, 2014 which would result in less employers being categorized as Small Group.¹⁹ There has been a shift in this market from Anthem (including Matthew Thornton) to Harvard Pilgrim Health Care.
- The Large Group Market has also decreased in market share from 46% to 41%, or from 105,000 members as of December 2013 to 96,000 members as of April 2015. The decrease in the Large Group may be correlated to the increase of 23,000 members in the self-insured market.

¹⁵ The estimate of 228,000 members in 2013 is based on Supplemental Report data 2014. The estimate of 235,000 members in 2015 is based on Annual Hearing data 2015 with a slight increase to account for carriers not captured in the Annual Hearing data.

¹⁶ Matthew Thornton Health Plan entered the NH Exchange in 2014. Harvard Pilgrim, Minuteman Health and Community Health Options entered in 2015 along with Assurant/Time.

¹⁷ Grandfathered plans are plans that were purchased before March 23, 2010.

¹⁸ Available at: http://www.nh.gov/insurance/media/bulletins/documents/ins_14_009_ab.pdf

¹⁹ The federal definition is based on total number of employees while the state definition was based on the number of eligible employees.

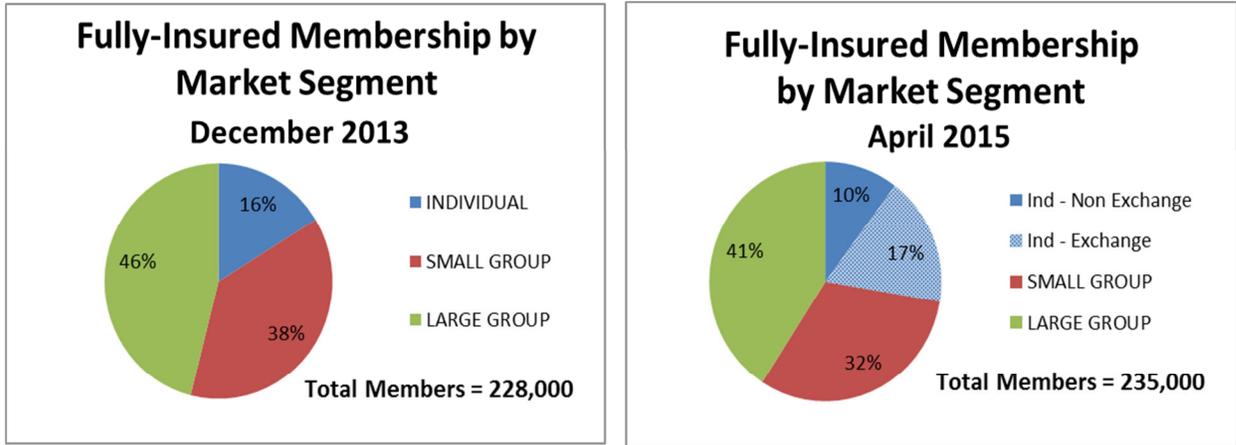


Figure 3: Fully-Insured Commercial Membership by Market Segment²⁰

Within the fully-insured markets, there has been a shift away from PPO products driven by changes to the Individual Market.

- The increase in HMO/POS/EPO products is driven by the introduction of limited network HMO products in the Individual Market Exchange. The Individual Market went from being almost 100% PPO/Indemnity prior to 2014 to only 24% as of April 2015.²¹
- The fully-insured Group Markets products have remained fairly stable and are currently at 76% HMO/POS/EPO as of April 2015.
- In the self-insured market, 45% of the market is in HMO/POS/EPO products as of April 2015.

²⁰ NHID Annual Hearing data 2014 and 2015; Excludes FEHBP; Includes Community Health Options and Minuteman Health.

²¹ Note that Anthem’s Pathway HMO products do not require members to select a primary care physician and they do not require members to obtain referrals to see other in-network providers.

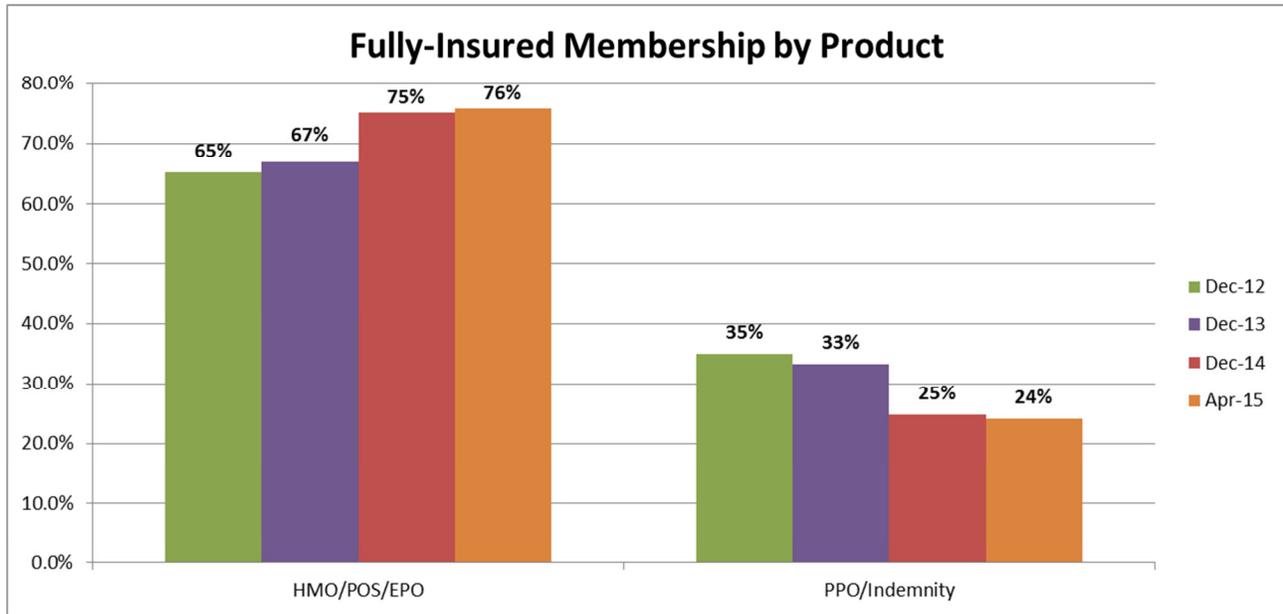


Figure 4: Fully-Insured Commercial Membership by Product²²

The FEHBP population represents a sizeable number of members in New Hampshire (48,000) and is generally analyzed separately. The FEHBP population is comprised of participants in the Federal Employees Health Benefit Program with coverage administered by a variety of carriers offering multiple plan options.

- Anthem, with 31,000 FEHBP members, administers FEHBP coverage under two different FEHBP plans for the Large Group market—one with no deductibles but copays, and the second with a \$350 deductible, coinsurance and some copays.

2. Premium Levels and Trends

Small Group and Large Group Market premium increases continue to be fairly small, while significant changes are seen in the Individual Market as a result of the ACA.

- The combined Small Group and Large Group unadjusted²³ premium trend was 3.6% in 2013 and 2.8% in 2014. These 2014 trends in New Hampshire are consistent with information from Kaiser’s Employer Benefits Health Survey showing national trends of 2.4% and 2.9% for single and family coverage,

²² NHID Annual Hearing data 2013, 2014 and 2015; Excludes FEHBP; includes Community Health Options and Minuteman Health.

²³ Unadjusted means that premiums trends have not been adjusted to reflect the impact of changing benefits and cost sharing.

respectively, in 2014.²⁴ The Kaiser report also provides estimates of 2015 premium trends, which are 4% higher compared to 2014.

- It is also interesting to note that self-insured premium equivalents trends in New Hampshire have remained fairly low at 1.6% in 2014.
- The Individual Market experienced significant change in average premium per member per months (PMPMs) as a result of the ACA:
 - Carriers expected higher morbidity and higher average age as a result of the influx of members, many of whom came from the state’s high risk pool resulting in significant increases to premiums.²⁵
 - These increases were partially off-set by the introduction of new limited network HMO product offerings on and off the exchange. Previously, the Individual Market had been dominated by PPO products with broad or full networks.
 - The premiums shown below do not reflect premium subsidies for qualifying low income individuals.²⁶
- The average age in Small Group and Large Group Markets has remained fairly steady, although we do see a slight increase going into April 2015.
- The average age has increased dramatically in the Individual Market, which is not surprising given the influx of members coming from the state’s high risk pool.

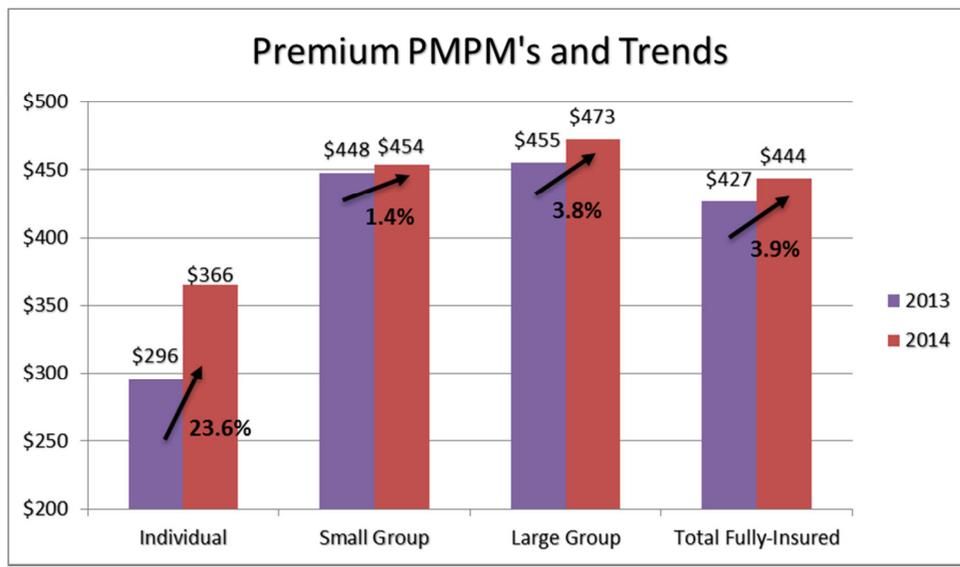


Figure 5: Fully-Insured Commercial Unadjusted Earned Premium by Market Segment²⁷

²⁴ Kaiser Family Foundation, 2015 Employer Benefits Health Survey, Exhibit 1.11. 2014 single and family premiums of \$6,025 and \$16,351 respectively. 2013 single and family premiums of \$5,884 and \$16,351 respectively. Available at: <http://kff.org/report-section/ehbs-2015-section-one-cost-of-health-insurance>

²⁵ The federal high risk pool ceased coverage as of April 30, 2014 and the state high risk pool ceased coverage as of June 30, 2014.

²⁶ Premium subsidies are available on a sliding-scale to individuals and families with incomes between 100-400 percent of the federal poverty level (FPL).

²⁷ NHID Supplemental Report data 2014 and 2015; Excludes FEHBP.

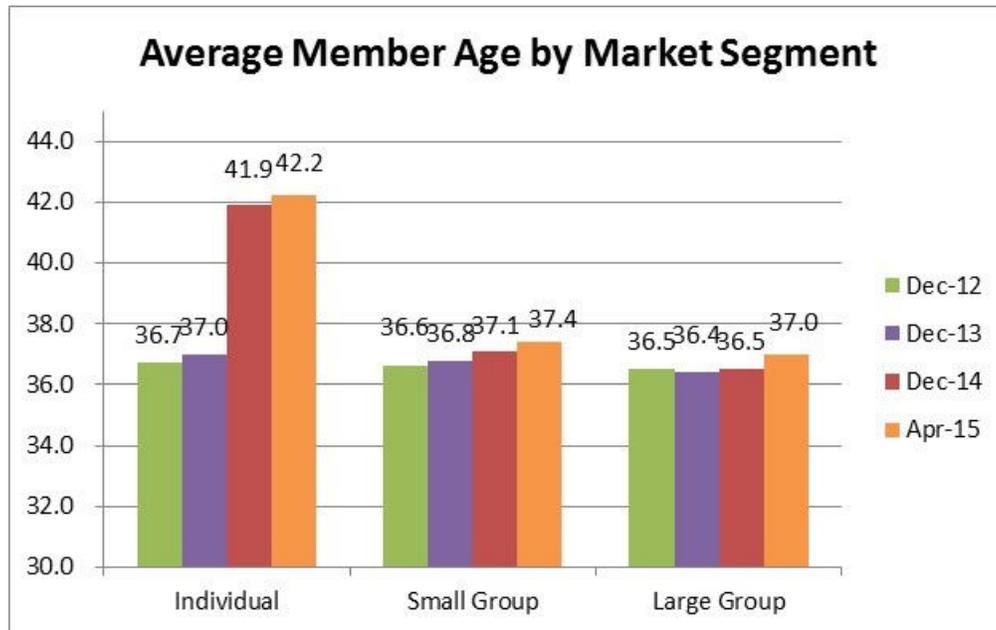


Figure 6: Average Age by Market Segment²⁸

Exchange premiums in the Individual Market are 17% higher than non-exchange premiums on average, prior to the impact of premium subsidies for qualifying low income individuals.

- Forty three percent (43%) of the Individual Market is non-exchange, with 57% on exchange in 2014. This enrollment changes to 37% non-exchange and 63% on exchange as of April 2015.
- Approximately 14% of non-exchange members are in limited network HMO products, while 86% are in PPO products. Exchange products are all limited network HMO products.
- The average age of Individual Market populations (both exchange and non-exchange) increased from December 2013 to December 2014, thus driving premiums increases in both populations.
- The average age of the exchange population is 7.4 years older than the non-exchange population as of April 2015.
- As of December 2014, 57% of the non-exchange market is either grandfathered or in transitional ACA products and therefore not subject to the same rating requirements as the non-grandfathered population. (The exchange population is all non-grandfathered.)²⁹

²⁸ NHID Annual Hearing data 2013, 2014 and 2015; Excludes FEHBP; Includes Community Health Options and Minuteman Health.

²⁹ NHID Annual Hearing data 2015.

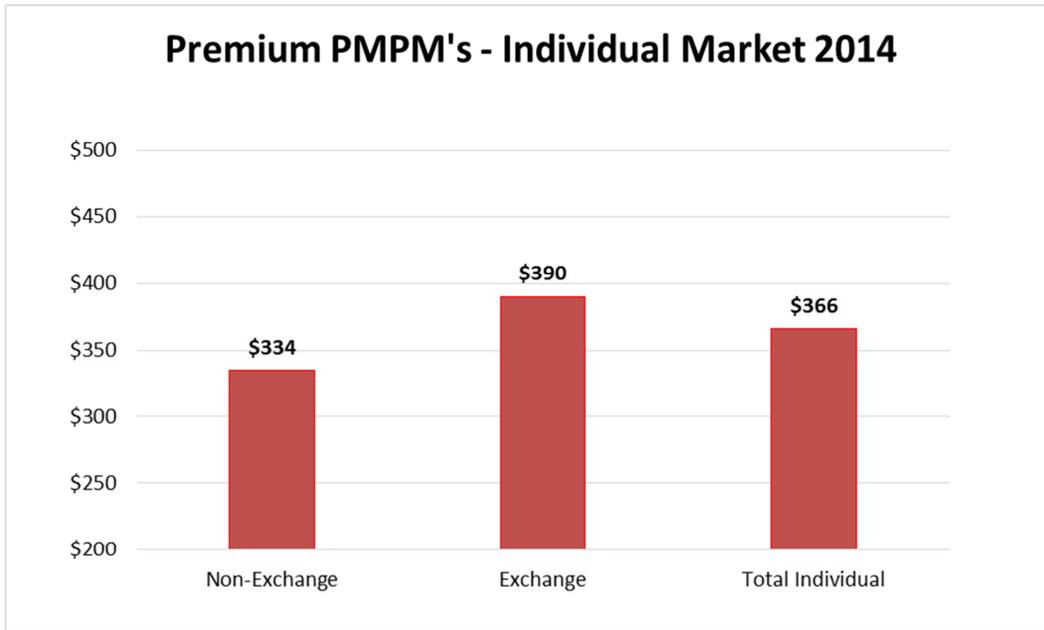


Figure 7: Non-Exchange and Exchange Premiums in the Individual Market CY 2014³⁰

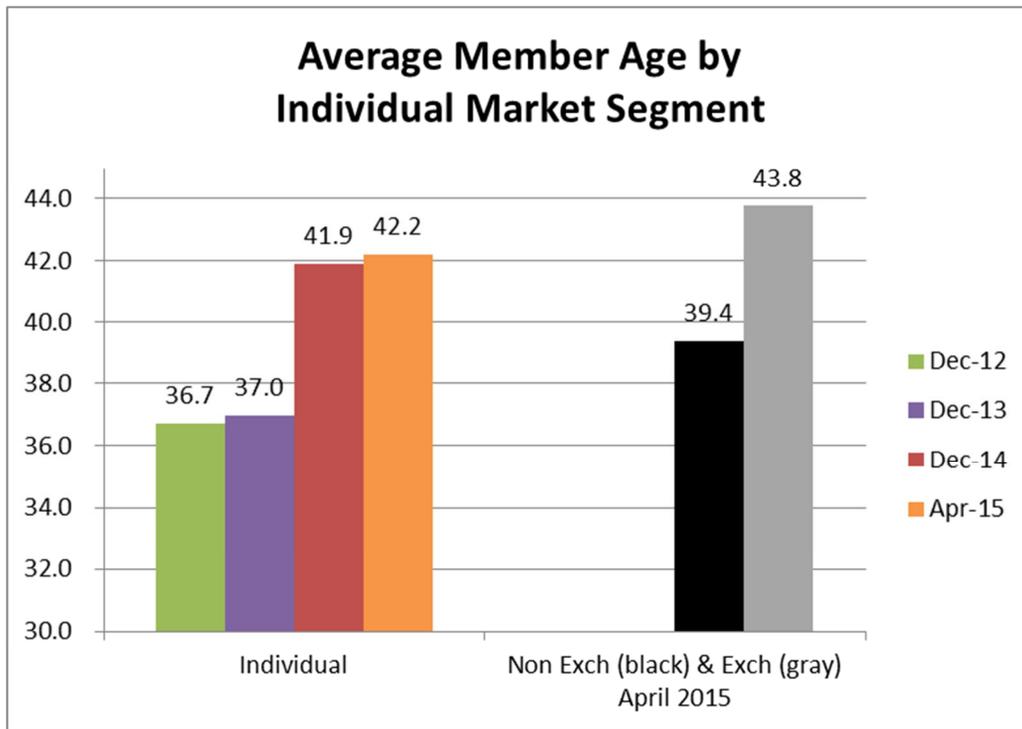


Figure 8: Average Ages of Individual Market Populations (Non-Exchange and Exchange)³¹

³⁰ NHID Supplemental Report data 2015.

³¹ NHID Annual Hearing data 2015.

3. Member Cost Sharing

While premium trends have remained low, members in both the Small Group and Large Group Markets continue to shift towards plans with higher deductibles.

- Between CY 2012 and CY 2014, the percentage of members with a deductible of \$3,000 or greater increased from 48% to 68% in the Small Group Market and from 37% to 46% in the Large Group Market.
- These shifts were fairly consistent in 2013 and 2014 for the Large Group Market, and there was a slightly greater shift in 2013 compared to 2014 for the Small Group Market.
- The average deductible in the Small Group Market increased \$235 or 8% in 2014 compared to 2013, while the average deductible in the Large Group Market increased \$145 or 6%. These increases are slightly lower than the increases from 2012 to 2013.
- The average deductibles in the Small Group Market are about \$622 higher than in the Large Group Market.

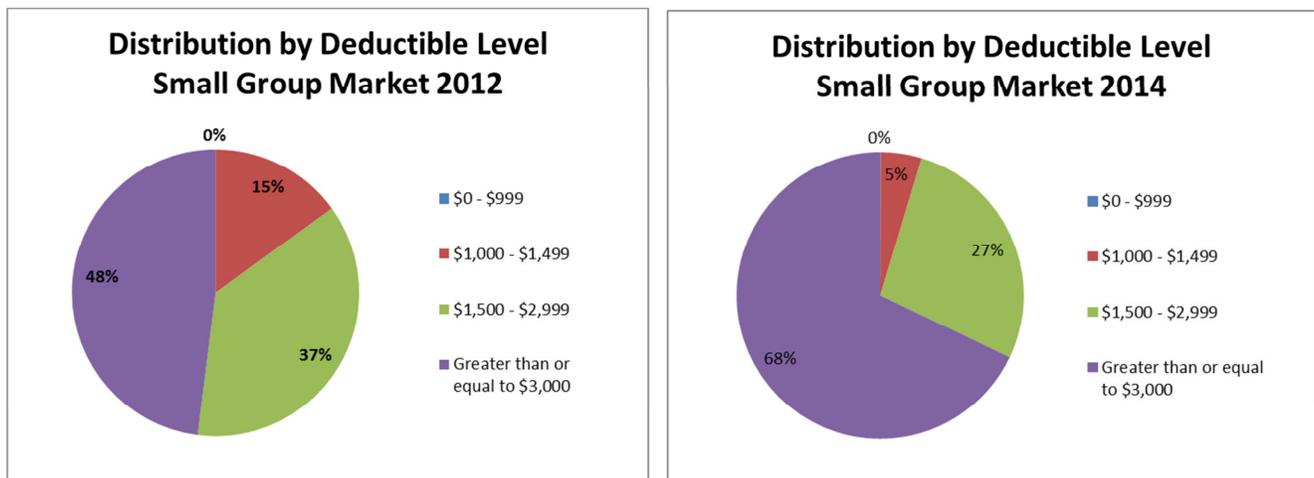


Figure 9: Small Group Market Distribution of Deductibles CY 2012 and CY 2014³²

³² NHID Supplemental Report data 2013 and 2015.

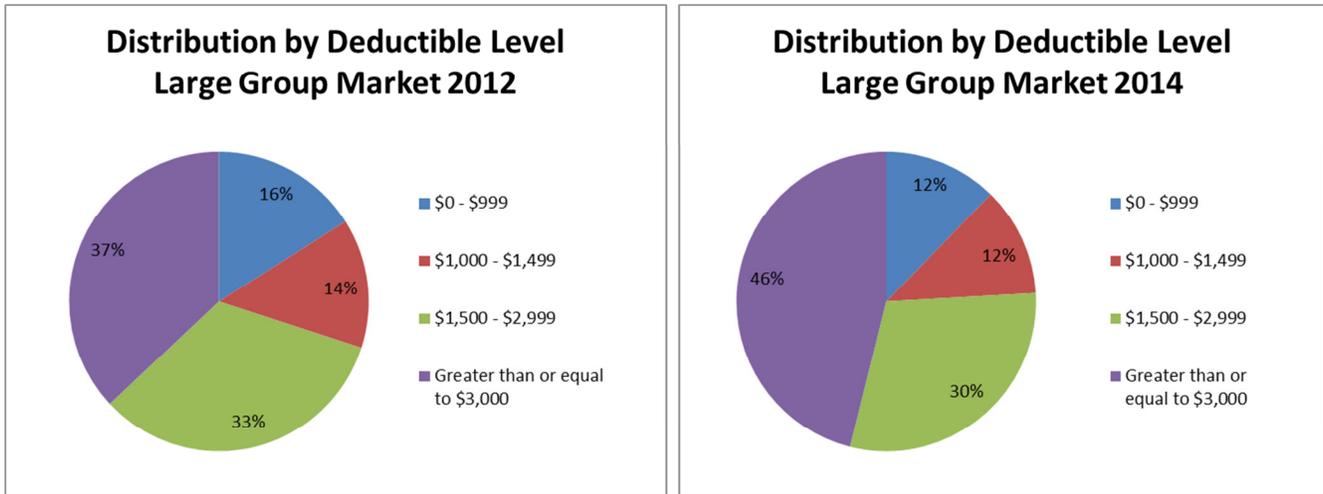


Figure 10: Large Group Market Distribution of Deductibles CY 2012 and CY 2014³³

	Small Group		Large Group	
	2013	2014	2013	2014
Average Deductibles	\$2,847	\$3,082	\$2,315	\$2,460
Average Member Coinsurance	2%	4%	3%	5%
Average OOP Maximum	\$3,489	\$3,824	\$3,382	\$4,962
% of Members in High Deductible Health Plans	15%	26%	19%	35%

Table 1: Cost Sharing Attributes for Small Group and Large Group by Year³⁴

Overall deductible levels in the Individual Market in CY 2014 are very different compared to prior years, due to the introduction of cost sharing reduction (CSR) subsidies for qualifying low income individuals.^{35, 36}

- When comparing the Individual Market to prior years, overall deductible levels have generally decreased. In CY 2014, 21% of the market have deductibles between \$0 - \$999 versus 1% in CY 2012.
- The distribution of members by deductible level for just the Individual Non-Exchange Market in CY 2014 is more similar to the Individual Market in CY 2012 and shows members shifting to higher deductibles.

³³ NHID Supplemental Report data 2013 and 2015. Fully Insured Only. Excludes FEHBP.

³⁴ NHID Supplemental Report data 2014 and 2015. Fully Insured Only. Excludes FEHBP. Average deductibles include deductibles of \$0. OOP Max averages include members in plans with no OOP max (this represents 10% of Small Group members and 12% of Large Group members.)

³⁵ Cost Sharing Reduction Subsidies (CSR) lower out-of-pocket costs, based on income, for silver plans bought on the exchange for low income individuals between 100% and 250% of the federal poverty level. CSR plans lower the amount members have to pay out-of-pocket for deductibles, coinsurance, and copayments. In 2014, each of the three silver plans offered on the exchange have three CSR variants, corresponding to the three levels of CSR subsidies: CSR 73, CSR 87, and CSR 94. The numbers refer to the actuarial value (AV). Members are eligible for CSR plans based on their income: 100-150% FPL = 94% Actuarial Value (CSR 94); 150-200% FPL = 87% Actuarial Value (CSR 87); 200-250% FPL = 73% Actuarial Value (CSR 73).

³⁶ All deductibles and other cost sharing reflect the reduced amounts after the impact of the cost sharing reduction subsidies.

Between CY 2012 and CY 2014, the percentage of members with a deductible of \$3,000 or greater increased from 42% to 50% in the Individual Non-Exchange Market.

- The CSR members in the Individual Exchange Market are driving the shift to overall lower deductibles in CY 2014. In CY 2014, there is an average of 13,000 CSR members. This represents 45% of the exchange population and 26% of the total Individual Market. Seventy nine percent (79%) of CSR members are in plans with deductibles between \$0 and \$999.³⁷ Of the members with a CSR plan, 50% are in the CSR 94% plan, 35% are in the CSR 87% plan and the remaining 15% are in the CSR 73% plan.
- Average deductibles in the Individual Market are \$2,781 in 2014, approximately 24% lower than the prior year; again, this is driven by the CSR members.

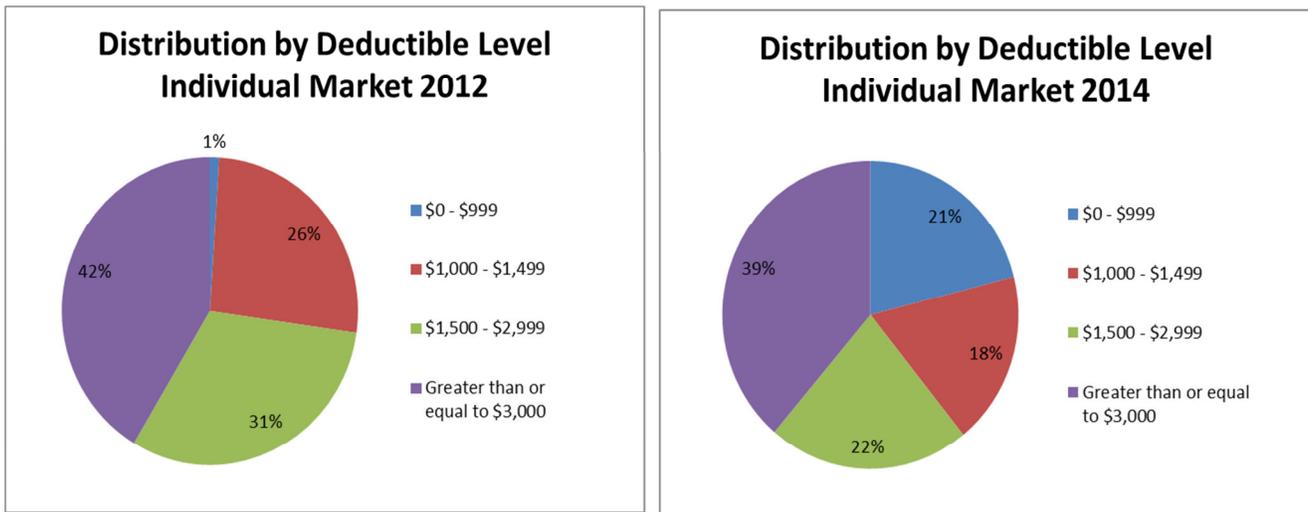


Figure 11: Individual Market Distribution of Deductibles CY 2012 and CY 2014³⁸

³⁷ In the Supplemental Report data, the premium reported for CSR members represents a silver plan premium (actuarial value of 70%) while the cost sharing elements and actuarial values reported reflect those of the member's corresponding CSR plan (i.e. either 94%, 87% or 73% actuarial value).

³⁸ NHID Supplemental Report data 2013 and 2015.

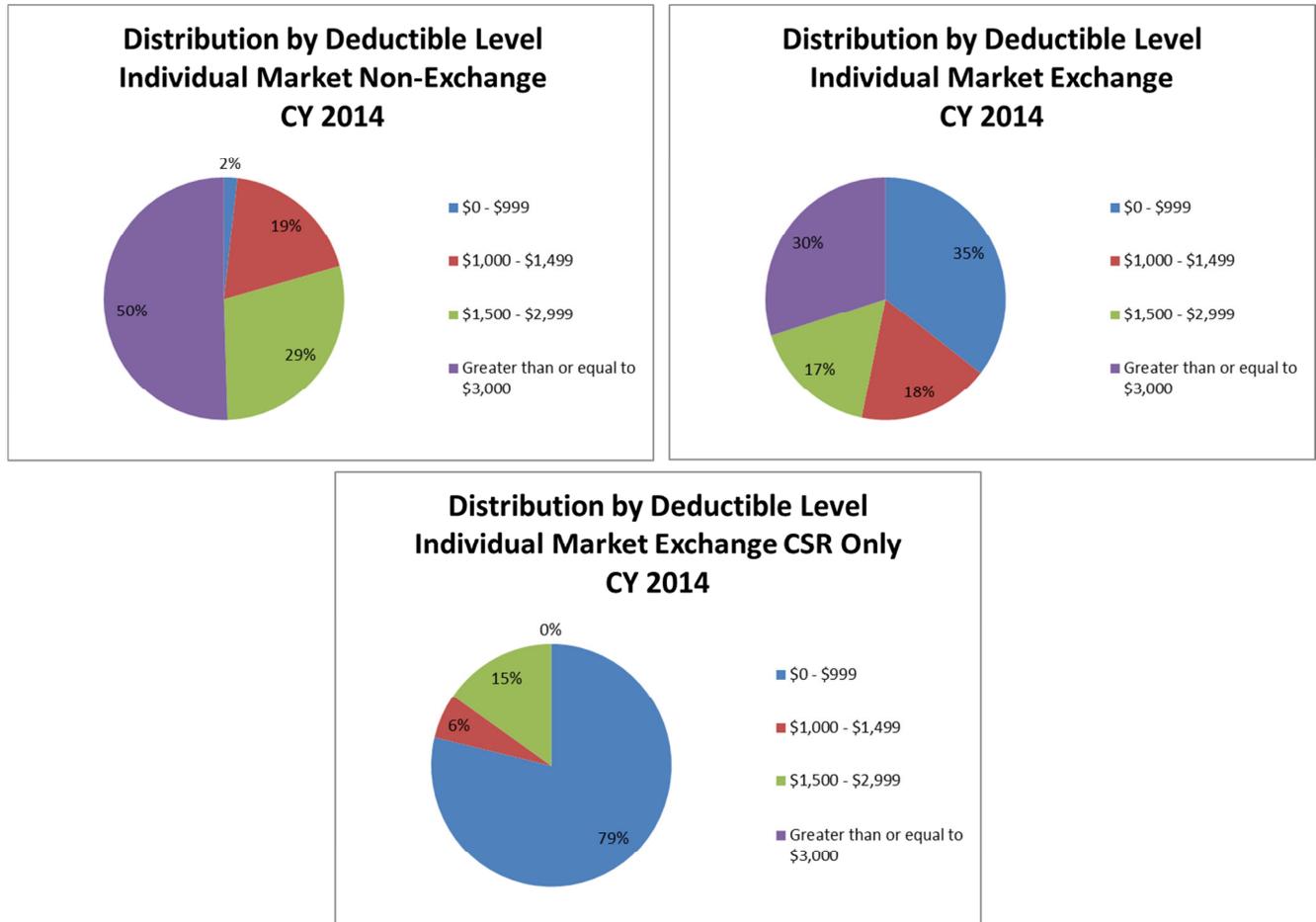


Figure 12: Individual Market Distribution of Deductibles CY 2014 for Non-Exchange, Exchange and CSR Only³⁹

Members in state and municipal plans generally have lower cost sharing than other self-insured members.⁴⁰

- The vast majority of state and municipal members identified by carriers are in self-insured plans.
- The data identified by carriers as state plans all have a \$500 deductible, no coinsurance and an out-of-pocket maximum of \$1,000.
- The municipal population shows much lower average deductible and coinsurance amounts compared to the non-state and non-municipal self-insured population. Note that nearly 70% of the municipal population has no deductible compared to 30% in the non-state and non-municipal self-insured market.

³⁹ NHID Supplemental Report data 2015.

⁴⁰ The New Hampshire Purchasers Group on Health is a collaboration of the state’s four largest public health care purchasers: State of New Hampshire Employee Health Benefit Program (administered by Anthem and Matthew Thornton Health Plan), HealthTrust (administered by Matthew Thornton and Anthem), New Hampshire School Health Care Coalition (administered by CIGNA) and the University System of New Hampshire (administered by Harvard Pilgrim). The State of New Hampshire Employee Health Benefit Program is represented by the “State” designation in the 2015 Supplemental Report data. The HealthTrust and New Hampshire School Health Care Coalition are part of the “Municipal” population in the 2015 Supplemental Report data. The University System of New Hampshire is not currently identifiable in the Supplemental Report data and is part of the “Other Self-Insured” population.

- Seventy three percent (73%) of the municipal membership are in plans with a \$6,350 out-of-pocket maximum, which causes the average out-of-pocket maximum for the municipal population to be higher than the general self-insured population.

Market Segment	Average Deductible	Average Coinsurance	Average OOPMAX	Number of Members
State	\$500 for All	No Coinsurance for All	\$1,000 for All	29,000
Municipal Self-Insured	\$202	1.5%	\$4,259	87,000
Other Self-Insured Market (excluding State, Muni)	\$1,013	10.5%	\$3,018	140,000

Table 2: Comparison of State and Municipal Cost Sharing to Self-Insured Population CY 2014⁴¹

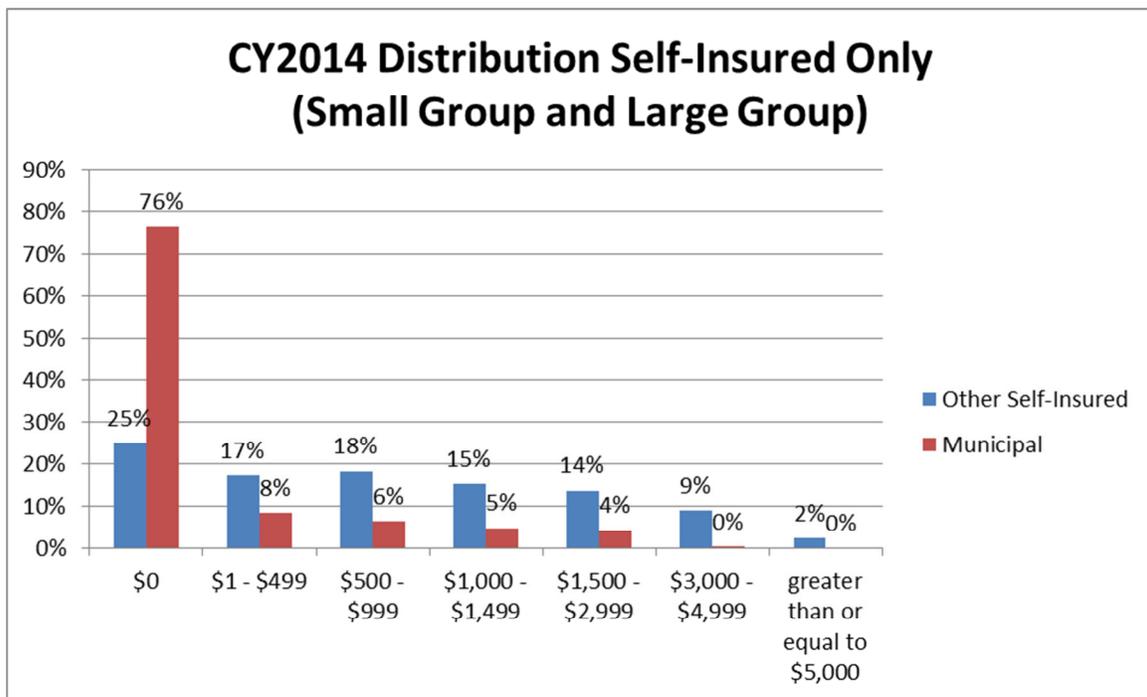


Figure 13: Distribution of Municipal and Other Self-Insured by Deductible Level⁴²

On average in the commercial fully-insured markets in CY 2014, 19% of total allowed claims are paid by members in the form of deductibles, copays and coinsurance.

- In 2014, the percentage of member cost sharing as a percentage of total allowed claims is 24% in the Individual Market, 21% in the Small Group Market and 17% in the Large Group Market.
- This translates to the average member spending \$81 per month or \$972 per year on out of pocket health care expenses for copays, coinsurance and deductibles. These amounts have increased in each market segment for the last couple of years with the exception of the Individual Market (this is impacted by the CSR subsidies in the Individual exchange.)

⁴¹ NHID Supplemental Report data 2015.

⁴² Ibid.

- In the 2014 Individual Market, where a member is responsible for 100% of the premium as there is no employer contribution, the average member is paying \$366 in premiums per month and \$74 in cost sharing per month for a total of \$440 per month or \$5,280 per member per year. Therefore, a family of four who participates in the Individual Market pays \$21,120 per year on average. This does not reflect the premium subsidies for low-income enrollees in the Exchange.

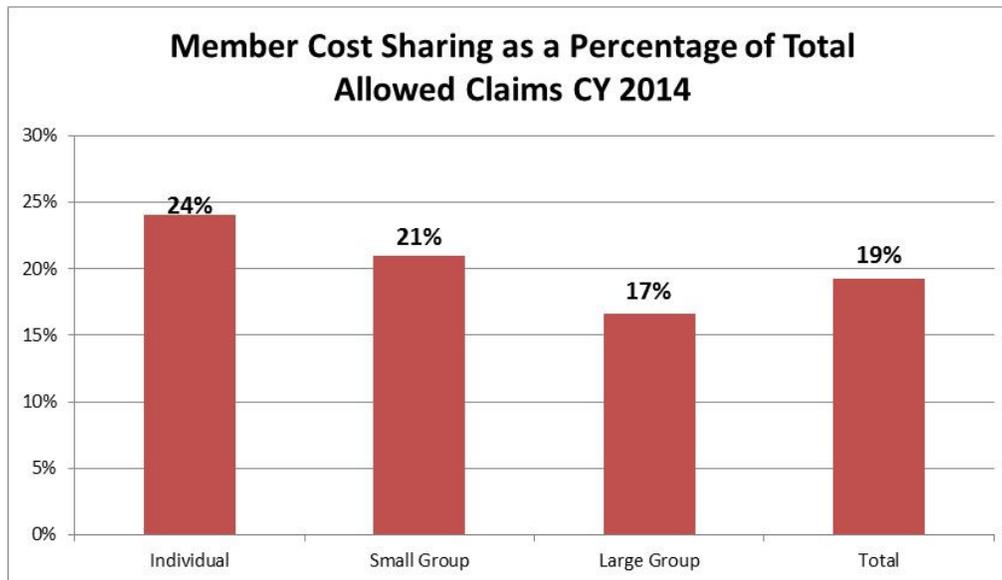


Figure 14: Member Cost Sharing as a Percentage of Total Allowed Claims by Market Segment CY 2014⁴³

4. Benefit Buy-Down and Benefit Adjusted Premium Trends

Benefit buy-down in the Small Group and Large Group Markets were very similar this year compared to last year.

- “Benefit buy-down” is the process of selecting a plan with reduced benefits or higher member cost-sharing as a way to mitigate premium increases. Benefit buy-down is estimated by reviewing changes in cost sharing attributes along with carrier reported actuarial values using the federal minimum value calculator.
- The Individual Market is impacted by the introduction of cost sharing reduction subsidies for qualifying low-income individuals; therefore, the average cost sharing levels decrease in this segment compared to 2013.
- Small Group members experienced benefit buy-down of 2% to 4% while Large Group experienced benefit buy-down of 1% to 3%.

⁴³ NHID Supplemental Report data 2015.

	2014 Benefit Buy-Down Range
Individual	n/a
Small Group	2% to 4%
Large Group	1% to 3%
Total Group Only	2% to 4%

Table 3: Benefit Buy-Down by Market Segment⁴⁴

If employers did not change their 2013 plan designs, in 2014 the Small Group Market would have experienced average premium increases in the range of 3% to 6% and the Large Group Market would have experienced average premium increases in the range of 5% to 8% (benefit-adjusted premium trends).

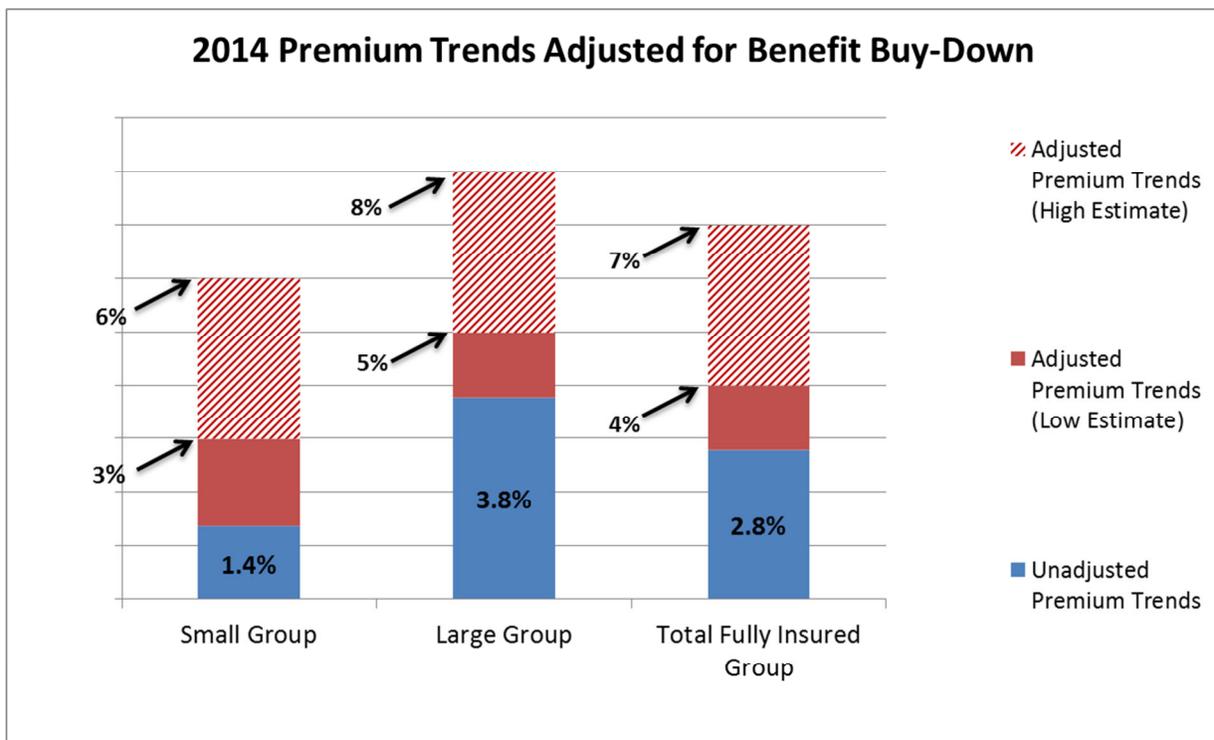


Figure 15: 2014 Premium Trends Adjusted for Benefit Buy-Down⁴⁵

⁴⁴ Derived based on actuarial values and cost sharing attributes from the NHID Supplemental Report data 2014 and 2015; Fully-Insured Only, Excludes FEHBP.

⁴⁵ Ibid.

5. Claims Trends

Observed allowed claims PMPM trends remains low in the fully-insured market at 2.0% overall and the combined Small Group and Large Group Market Trend is 0.5% in 2014.

- Small Group Market trends in 2014 have decreased slightly compared to 2013 while Large Group Market trends have increased slightly compared to 2013, but overall remain low.
- The high Individual Market trend is driven by the dramatic changes to the Individual Market as a result of the ACA described previously. The 15.7% trend is a result of utilization trends over 30% (primarily driven by influx of newly insured and former high risk pool members). This is partially offset by cost and mix trends below -10% (primarily driven by the introduction of the limited network HMO product for exchange and non-exchange members.) As a result of these dramatic changes, it is difficult to make meaningful comparisons in the Individual Market.

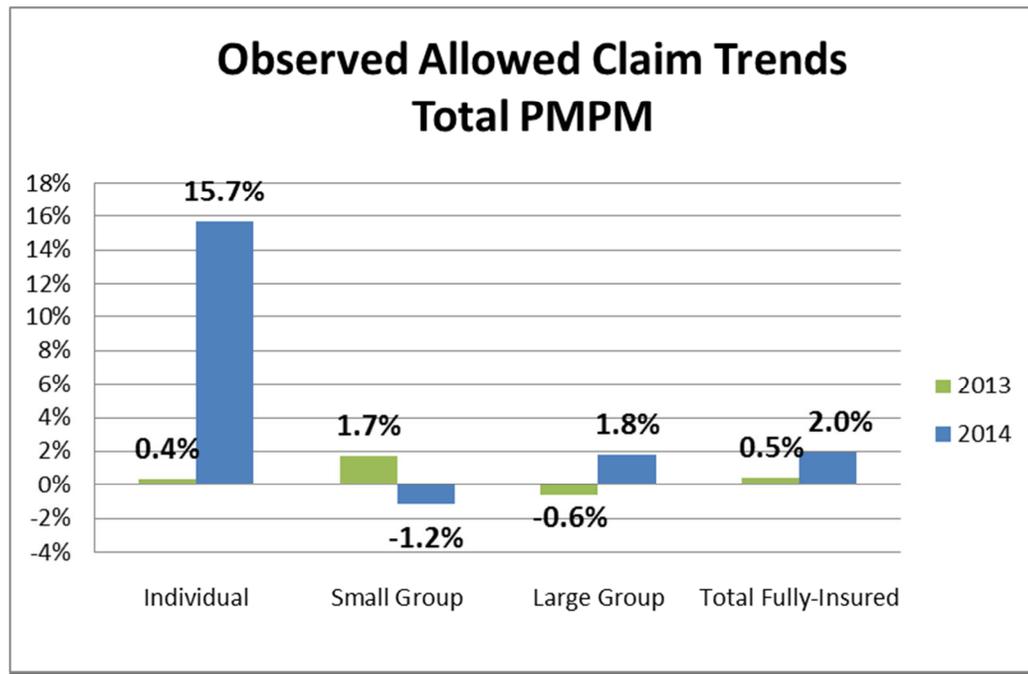


Figure 16: Observed Allowed Claims Trend by Fully-Insured Market Segment⁴⁶

Utilization trends have remained negative and mix trends have remained fairly small, while the offsetting increase in unit cost continues to be the main driver of medical costs increases.

⁴⁶ NHID Annual Hearing data 2015. Trends weighted by allowed claims in corresponding years.

- Claims PMPM trends generally consist of two components: Utilization and Cost & Mix. Utilization is the number of services provided (e.g. admissions to a hospital or number of prescriptions filled). Cost trends are a combination of the change in unit price of specific services and changes in the mix of services or changes in the mix of providers being used by patients.
- Consistent with last year’s findings, utilization trend has been the major driver of the overall lower PMPM trends in recent years at -2.8% in 2014 and a combined -6.0% over the two years from 2012 to 2014.
- The “mix” portion of the cost & mix trends is estimated to be around +1% to -1% over the past couple of years.
- Unit cost trends continue to be the main driver of overall claims trends. The cost & mix trend is 3.6% in 2014, although there was some moderation compared to last year’s trend of 4.3%. The combined two year cost & mix trend is 7.9%.

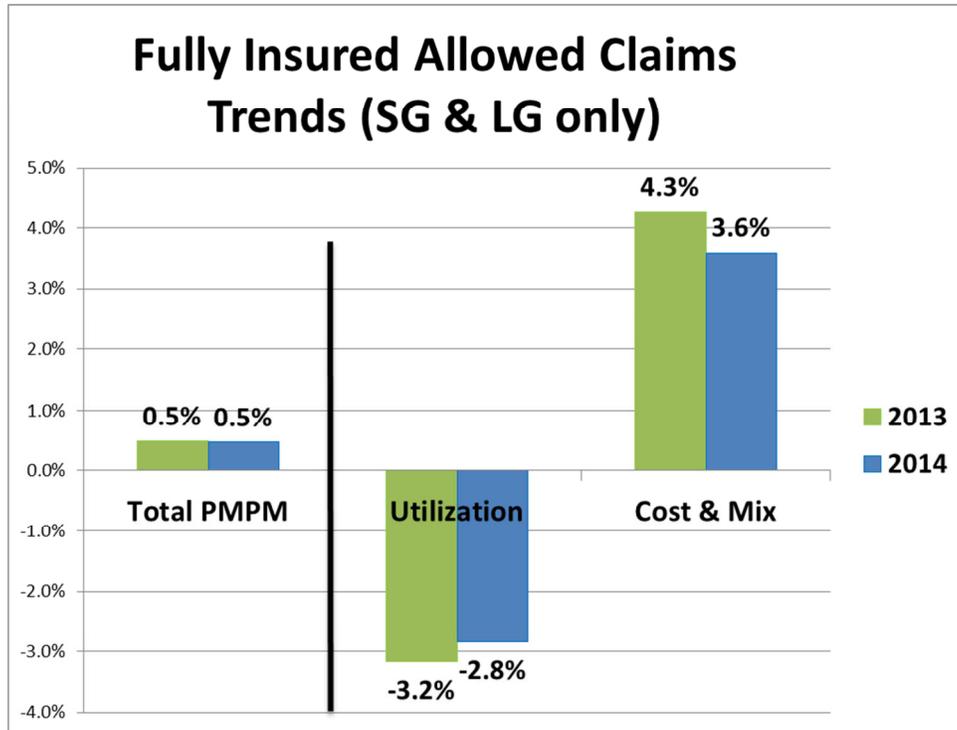


Figure 17: Observed Allowed Claims Trend by Component in Fully-Insured Small and Large Group Markets⁴⁷

Allowed claim trends by service category have remained fairly stable with the exceptions of professional and pharmacy services.

⁴⁷ NHID Annual Hearing data 2015. Utilization and cost trends reported by service categories and in total by categories. Total utilization and cost trends are generally weighted by service category allowed PMPM’s. Utilization metrics generally reflect admits for inpatient, prescriptions for pharmacy and visits for professional and outpatient categories.

- The lower Professional trend is driven by a combination of both lower cost & mix trends and lower utilization trends.
- The increase in Pharmacy trend is driven by a large increase in the cost & mix trends. Carriers cited the increases are due to fewer saving from brand to generic conversions along with new and costly specialty drugs such as those to treat Hepatitis C.
- Each service category in each year experienced either flat or negative utilization trends.
- The percentage of total allowed claims for each service category has remained fairly consistent over the past couple years with the most significant increases seen in the pharmacy category as pharmacy trends have been higher in recent years than overall medical trends. Pharmacy currently reflects 18% of total allowed spending in the fully-insured market.
- Inpatient and outpatient hospital spending comprises 43% of total medical spending, followed by professional spending at 28%.

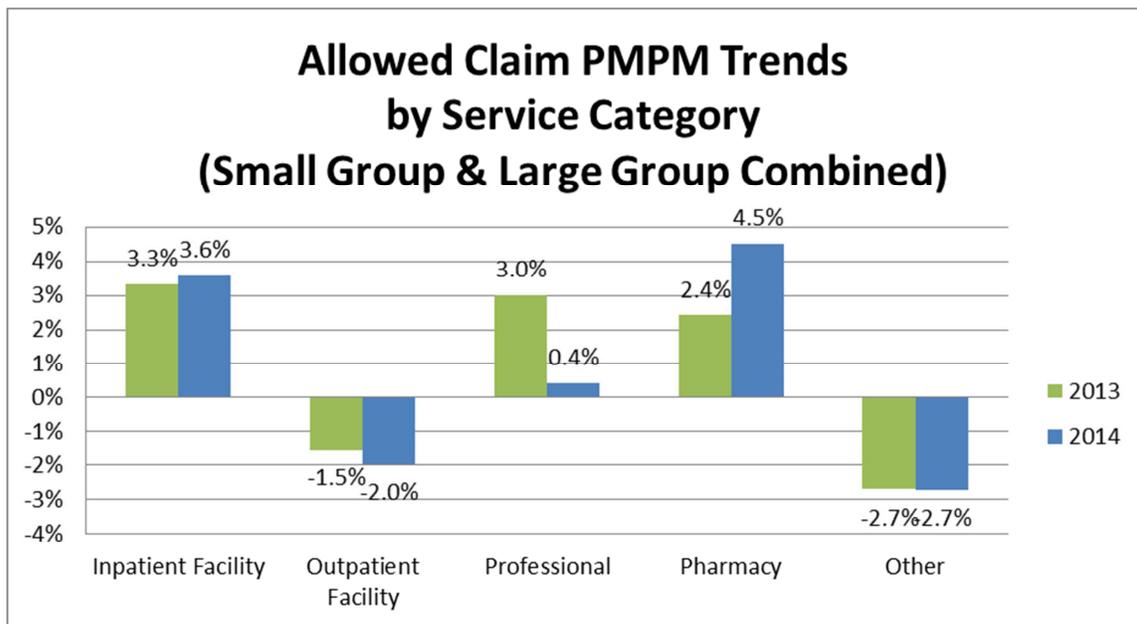


Figure 18: Observed Allowed Claims PMPM Trend by Service Category⁴⁸

⁴⁸ NHID Annual Hearing data 2015. FFS claims only.

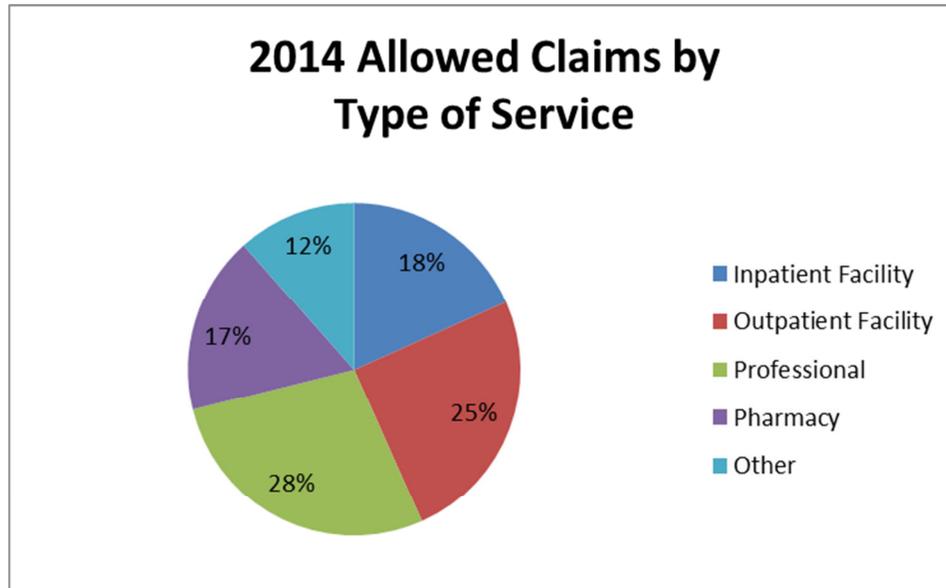


Figure 19: CY 2014 Allowed Claims Percentage by Service Category⁴⁹

Pricing trends in the fully-insured markets have decreased over the past several years from a high of 10.5% in 2012 to 7.5% in 2016 driven by decreases in the pricing trend for medical services partially offset by increases in the pricing trends for pharmacy services.

- Health insurance premiums are established well in advance of their effective period which requires insurance carriers to develop projected trend assumptions called pricing trends. Pricing trends are based on a static level of benefits while observed trends will reflect the impact of benefit changes to utilization levels. Also, given the significant lag between observed historical data and the projection period for a pricing trend, it may take time to see the same deceleration in pricing trends compared to what is occurring in observed historical trends.
- In 2016, the medical services pricing trend is around 6% while the pharmacy pricing trend is around 15% for an overall average of 7.5%.
- The 2016 Segal Health Plan Cost Trend Survey⁵⁰ reported average projected 2016 trends of 6.8% to 8.0% for medical services and 11.3% for pharmacy services.

⁴⁹ NHID Annual Hearing data 2015. FFS claims only.

⁵⁰ 2016 Segal Health Plan Cost Trend Survey. Available at: <http://www.segalco.com/media/2139/me-trend-survey-2016>

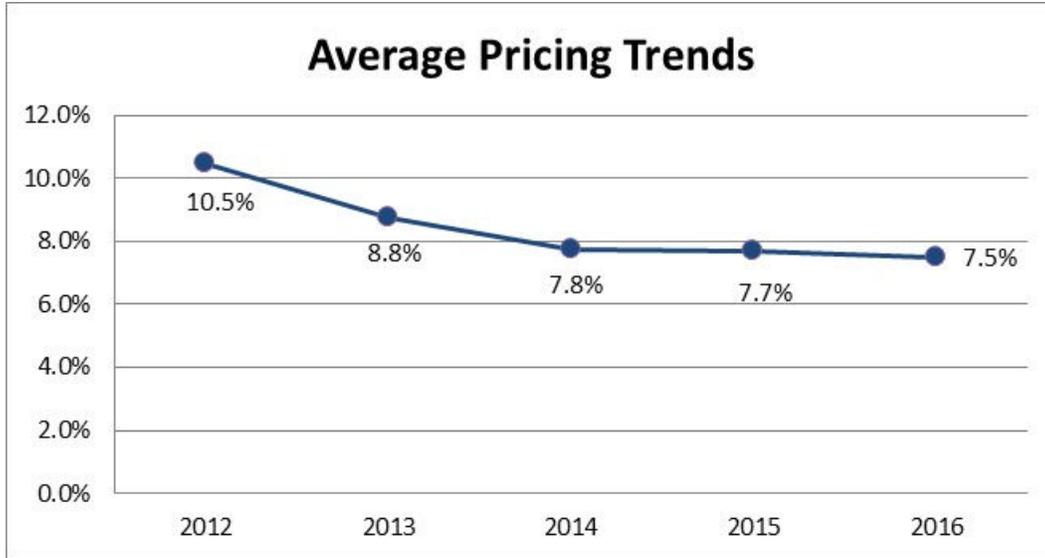


Figure 20: Average Pricing Trends in the Fully Insured Market⁵¹

⁵¹ NHID Annual Hearing data 2013, 2014 and 2015.

6. Provider Costs and Provider Payment Reform

While the overall average blended inpatient and outpatient hospital payment rate changes have remained fairly stable, there is significant variation when examining rate changes across hospitals.

- The overall average hospital rate increase has remained fairly stable at 2.9% in 2014 and 3.2% in 2015, but the payment rate changes by facility vary considerably by hospital with variation seen in each of the three regions of New Hampshire.⁵² This is consistent with prior years' findings.
- The Northern region continues to have lower payment rate changes compared to the rest of the state.
- The single dark black line represents the December 2014 Northeast Medical Consumer Price Index (CPI) of 3.1%.⁵³ In prior years, the vast majority of hospitals (22 out of 26) had unit price changes above the Northeast medical CPI. This year, a slightly lower number of hospitals had payment rate changes that exceed the Northeast medical CPI (17 in 2014 and 18 in 2015). Note also that the Northeast Medical CPI has increased in the past year.

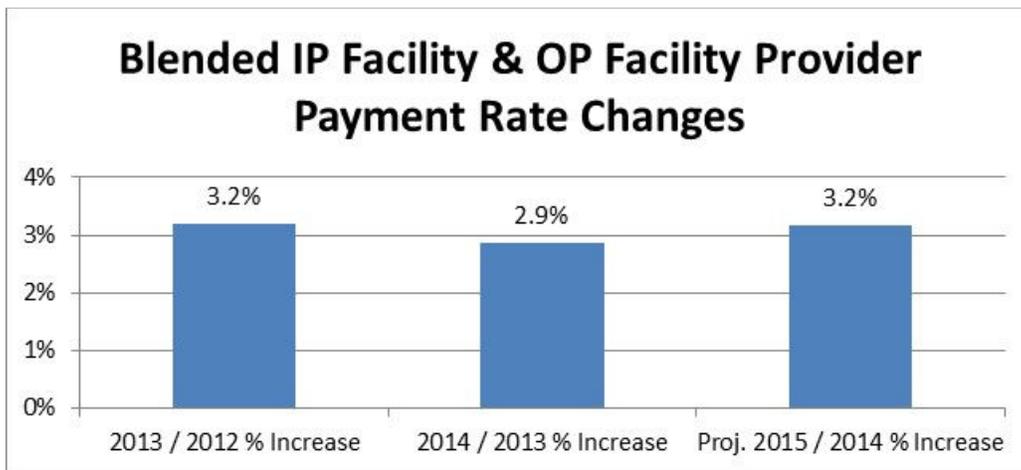


Figure 21: Blended Inpatient and Outpatient Average Hospital Payment Rate Changes by Year⁵⁴

⁵² Regions defined based on definition from the report "Analysis of Price Variations in New Hampshire's Hospitals" by the University of Massachusetts Medical School (UMMS). Available at: <http://www.nh.gov/insurance/lah/documents/umms.pdf>

⁵³ Medical CPI for December 2014 is available at: <http://www.bls.gov/cpi/cpid1412.pdf>, Table 11

The Northeast is defined as Connecticut, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island and Vermont. The CPI for Medical Care is based on both medical care services (professional services, hospital and related services and health insurance) and medical care commodities (medicinal drugs, medical equipment and supplies). For more information on how Medical CPI is calculated, see <http://www.bls.gov/cpi/cpifact4.htm>.

⁵⁴ NHID Annual Hearing data 2014 and 2015.

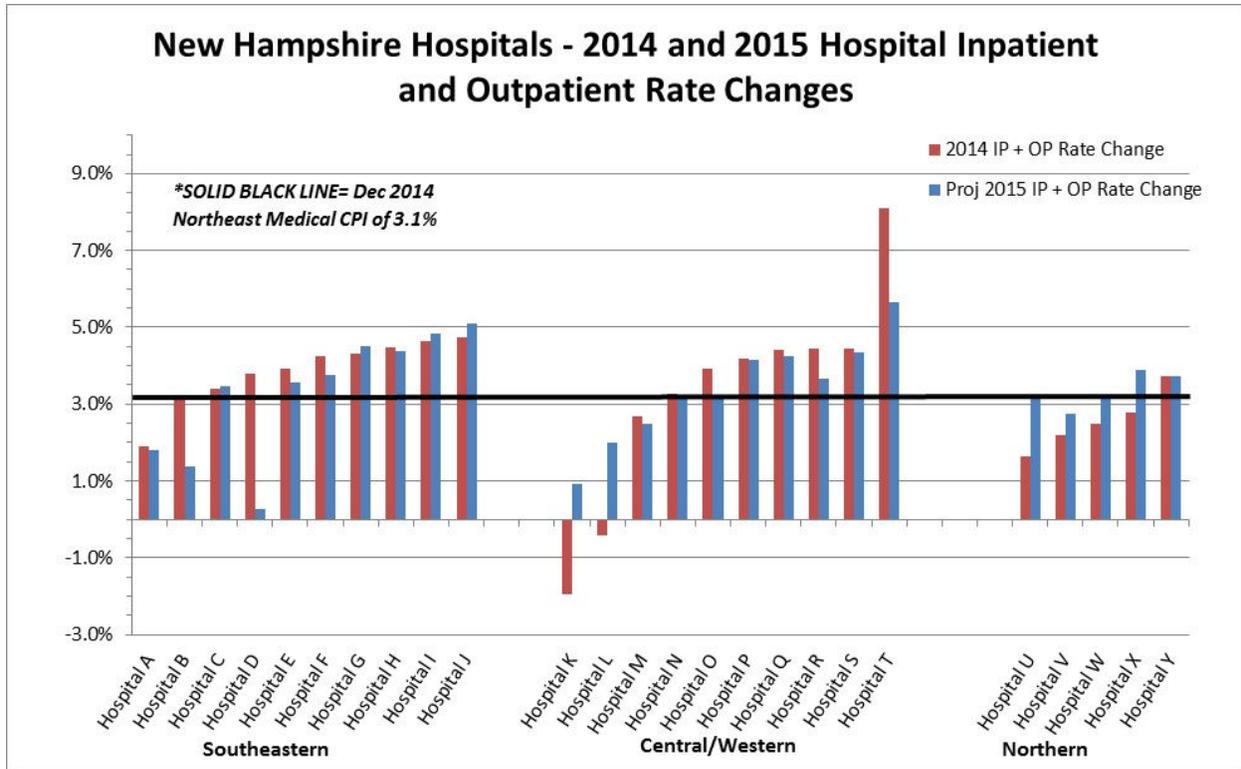


Figure 22: Blended Inpatient and Outpatient Hospital Rate Changes by Facility⁵⁵

In addition to variation in hospital payment rate changes, there continues to be variation in the level of hospital prices across all carriers that is not limited to a region or the amount of total commercial hospital payments for that hospital.

- Based on commercial relative prices as reported by carriers, the most expensive hospitals in New Hampshire continue to be more than twice as much as the least expensive hospital.
- The gray circles in the chart below represent total commercial inpatient and outpatient payments for each of the 26 acute care hospitals in New Hampshire. These hospitals are ranked from left to right based on their composite inpatient and outpatient relative price percentile – that is, the lowest priced hospitals are on the left and the highest priced hospitals are on the right.
- The least expensive hospitals are not limited to one region in New Hampshire, nor are they limited to hospitals with smaller commercial total hospital payments.

⁵⁵ NHID Annual Hearing data 2015. Medical CPI for December 2014 is available at: <http://www.bls.gov/cpi/cpid1412.pdf>, Table 11.

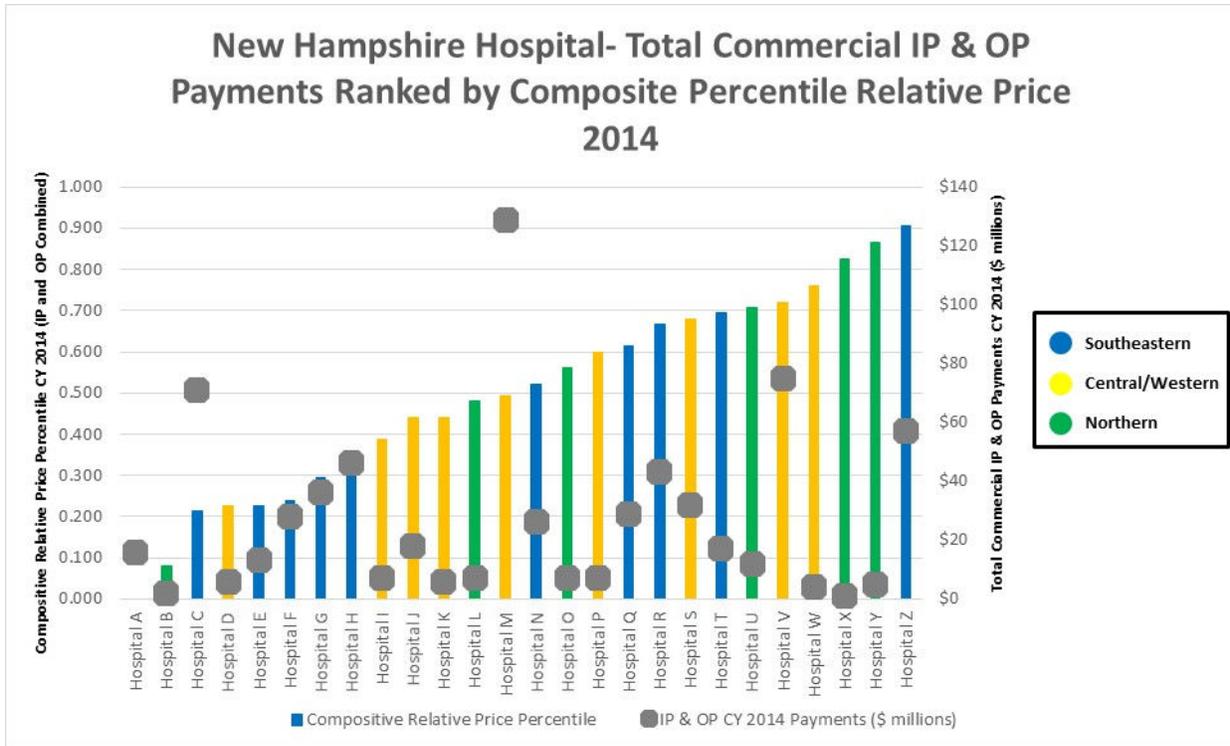


Figure 23: CY 2014 Total Commercial Inpatient & Outpatient Hospital Payments Ranked by Composite Relative Price-Combined Across Carriers⁵⁶

⁵⁶ NHID Annual Hearing data 2015. Relative prices are reported by each of the three carriers for Inpatient and Outpatient and then blended based on that carrier’s network wide inpatient and outpatient weights. These relative prices are then translated into percentiles for each carrier and a straight-line average is calculated.

Overall average professional payment rate changes are lower in 2014 and 2015 compared to 2013.

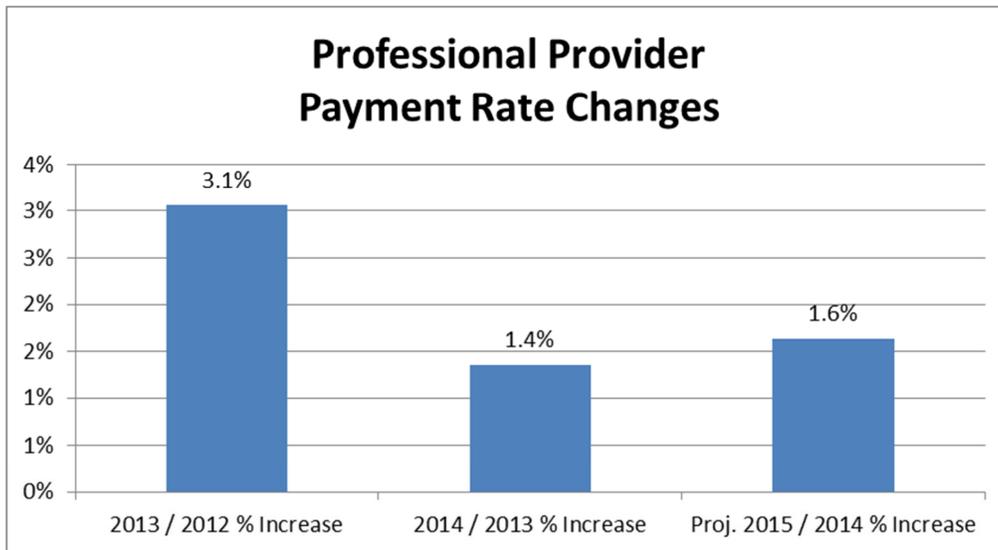


Figure 24: Professional Average Payment Rate Changes by Year⁵⁷

Uncompensated Care Costs for New Hampshire hospitals are important to track into 2014 and beyond to understand the potential impact of the Medicaid expansion, the decrease of the uninsured in New Hampshire, and other ACA and market dynamics.

- Uncompensated Care Costs (UCC) are generally defined as health care services provided by hospitals or providers that do not get reimbursed for a variety of reasons. This can be because patients do not have health insurance or do not have enough health insurance to cover the costs of their medical bills. Uncompensated care costs can also include underpayment from either Medicare or Medicaid reimbursement.
- Data were collected from both the New Hampshire Department of Health and Human Services (DHHS) and the New Hampshire Hospital Association (NHHA) to understand current levels of uncompensated care for New Hampshire acute care hospitals.
- DHHS determines UCC for purposes of calculating disproportionate share hospital (DSH) payments. DSH payments are made to qualifying hospitals that serve a large number of Medicaid and uninsured patients. DHHS follows federal guidelines to determine UCC for this purpose and generally includes unreimbursed Medicaid costs and costs for treating the uninsured. UCC as reported by DHHS for the state fiscal year 2015 DSH payment is based on the hospitals' fiscal year 2013 financial data and totals to \$285 million. The information received from DHHS is not comparable to the UCC information from NHHA given the differences in methodology and the purpose of the DHHS data being used exclusively for DSH payment calculations.

⁵⁷ NHID Annual Hearing data 2014 and 2015.

- NHHA compiles UCC information from the Internal Revenue Service 990 Schedule H Form for hospitals. These IRS forms are publically available and are considered an industry standard source for UCC. As compiled by NHHA in fiscal year 2013, the two largest categories of UCC are for unreimbursed Medicaid at \$243 million and unreimbursed Medicare at \$223 million. Community Benefits, which includes items such as grants to health care centers and community health initiatives, represent \$164 million. Bad debt and expenses represents \$160 million and financial assistance or charity care provided by hospitals represents \$86 million. Combined across these UCC categories, this totals to approximately \$875 million in FY 2013.

Uncompensated Care Costs- IRS 990 Schedule H	
FY 2013 (\$ millions)	
Unreimbursed Medicaid	\$243
Unreimbursed Medicare	\$223
Community Benefits	\$164
Bad Debt and Bad Debt Expenses	\$160
Financial Assistance (Charity Care)	\$86
Total	\$875

Table 4: Uncompensated Care Costs for New Hampshire Not for Profit Acute Care Hospitals in FY 2013⁵⁸

While there has been an increase in the percentage of members in risk sharing arrangements, the most significant increase is with members in upside only risk arrangements.

- The percentage of members in upside only risk contracts increased to 39% in the fully-insured markets and 42% in the self-insured markets. This increase was shown by all reporting carriers.
- Increases were also shown for members in full risk contracts with both upside and downside risk sharing, although not as significant as the increases as upside only risk contracts. The percentage of members in upside only risk contracts remains significantly higher than members in full risk contracts.
- Carriers reported on several payment reform initiatives including the following:
 - Primary Care Payment Models: At least two carriers in New Hampshire are working with primary care physicians to improve care coordination and outcomes by providing data, tools, and financial incentives to the provider groups for meeting certain cost and quality metrics. These arrangements primarily represent upside risk only to the provider. One carrier reported that 82% of New Hampshire providers are currently participating in this program.

⁵⁸ Information shared by the New Hampshire Hospital Association & Foundation for Healthy Communities. Source: FY 2013 990 Report, Schedule H. Note that one hospital is submitting an adjustment to the FY 2013 990, due to an omission in their filing. The amendment will include Other Community Benefits, totaling more than \$6 million. Parkland Medical Center and Portsmouth Hospital are not included in these totals as they are for-profit hospitals and not required to report uncompensated care costs.

- **Capitation:** Provider groups are fully at risk for the majority of services incurred by members. While not widely prevalent in New Hampshire, at least one large provider group participates in this arrangement. Historically, these arrangements are for HMO/POS members who choose a primary care provider (PCP), but at least one carrier has initiated a pilot program attributing PPO members to a PCP in 2014 and will continue the program into 2015.
- **Accountable Care Organizations:** At least two carriers have established accountable care type models with larger provider systems in New Hampshire. In one case, this arrangement is centered on sharing information with providers related to gaps in care and pharmacy compliance, and does not represent any financial risk sharing. In another case, the arrangement represented more of a true risk-sharing arrangement in which the provider shares in both upside and downside risk.
- **Hospital Pay for Performance Programs:** At least two carriers in New Hampshire participate in pay for performance type programs with hospitals, in which a portion of the hospital’s payment is tied to performance on a defined set of quality metrics. These programs typically apply to all fully-insured and self-insured HMO, POS and PPO members. One carrier reported eight participating hospitals in 2015 with another carrier reporting 15 participating hospitals in 2015.

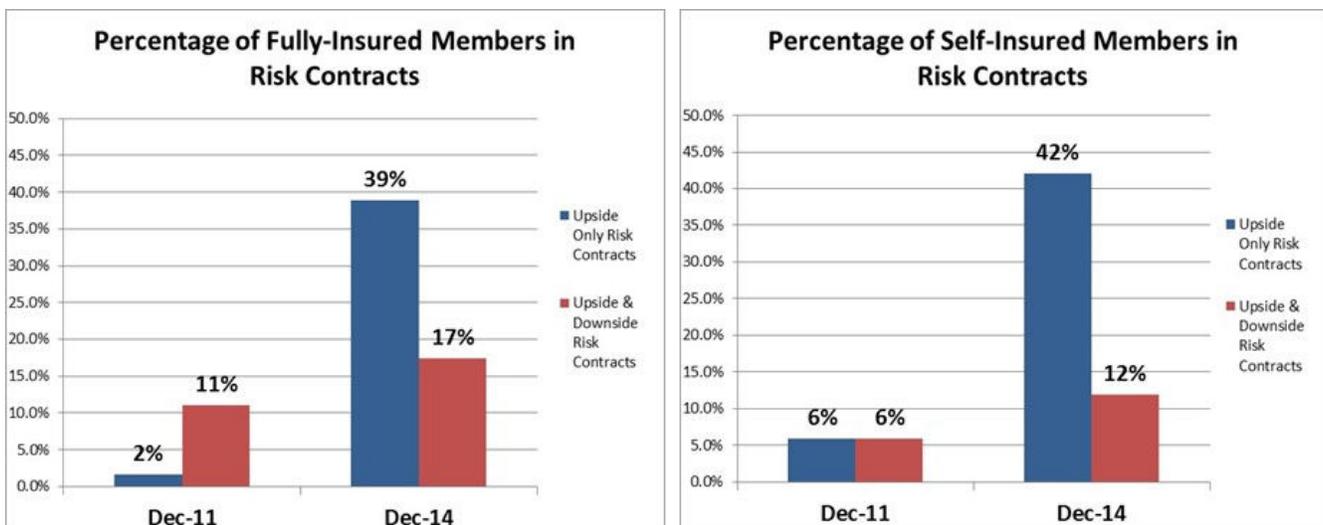


Figure 25: Members in Risk Arrangements for Fully-Insured and Self-Insured Markets⁵⁹

7. Medical Loss Ratios, Expenses and Profits

Overall, in the New Hampshire fully-insured market in 2014, 78% of premium was used to pay for medical and pharmacy claims, 7% was used for administrative expenses & fees, 7% for federal & state taxes, 3% for ACA related fees and taxes, and

⁵⁹ NHID Annual Hearing data 2013, 2014 and 2015.

5% for carrier profits. The Individual Market experienced the most change compared to 2013 where the overall profit margin has decreased.

- In CY 2014, the profit margins by market segment are fairly consistent, between 4% and 6%.
- The Individual Market experienced a significant decrease in the profit margin, decreasing from over 10% in 2013 to 4% in 2014. This is driven by an increase in the percentage of medical and pharmacy claims (as a percent of premium) and an increase in federal and state taxes.
- In the Individual Market, a higher percentage of premium goes toward administrative costs and non-ACA related taxes.
- In each market segment, about 3% of premiums are used for ACA related fees including the ACA health insurance tax, Patient-Centered Outcomes Research Institute (PCORI), and the transitional reinsurance fees.
- The percentage of claims for medical and pharmacy services is very consistent with last year’s results in the Group Markets.

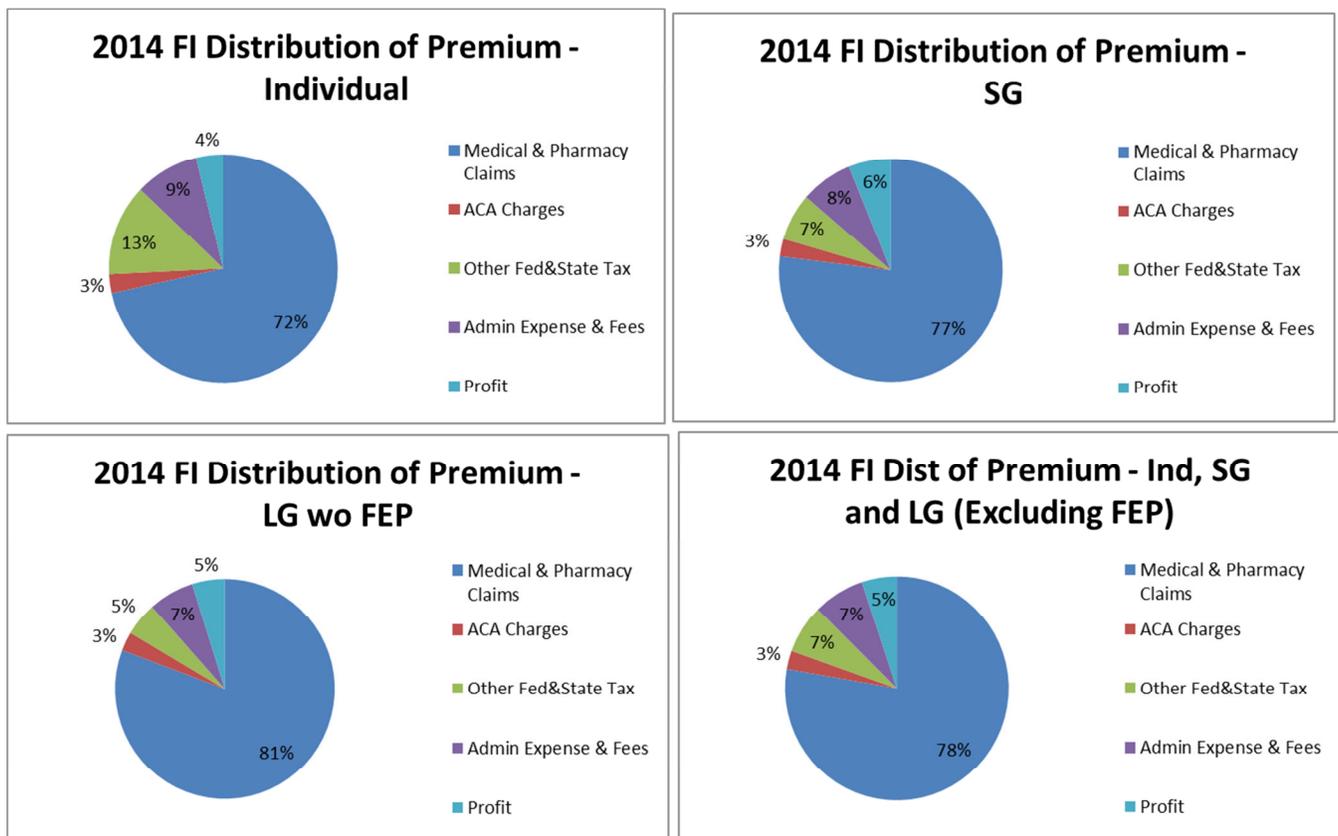


Figure 26: Loss Ratio Exhibits by Market for CY 2014⁶⁰

⁶⁰ 2014 federal MLR reports provided by carriers. Anthem provided additional information for FEHBP to make necessary adjustments to exclude from Large Group.

\$21.7 million in federal reinsurance payments were made to New Hampshire carriers. Additional monies were shared among carriers in New Hampshire for the risk adjustment program.

- The largest reinsurance payment was made to Matthew Thornton for \$15.6 million. This translates to 11% of their premium in CY 2014.
- The Risk Adjustment program is revenue neutral within the New Hampshire Individual Market and Small Group Market. In the Individual Market, Matthew Thornton has a higher risk population and receives \$5.3 million to cover losses due to the health status of their members. In the Small Group Market, Harvard Pilgrim Health Care of NE receives payments, primarily from Anthem and HPHC Insurance Company, and to a lesser extent from Matthew Thornton and United.

HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	STATE	REINSURANCE PAYMENT AMOUNT (OR NOT ELIGIBLE)	HHS RISK ADJUSTMENT TRANSFER AMOUNT (INDIVIDUAL MARKET, INCLUDING CATASTROPHIC)	HHS RISK ADJUSTMENT TRANSFERS AMOUNT (SMALL GROUP MARKET)
57601	Anthem Health Plans of NH (Anthem BCBS)	NH	Not Eligible		\$ 1,238,434
75841	Celtic Insurance Company	NH	\$ 100,260	\$ 57,417	
59025	Harvard Pilgrim Health Care of NE	NH	Not Eligible		\$ (2,973,746)
71616	HPHC Insurance Company, Inc	NH	Not Eligible		\$ 1,521,698
96751	Matthew Thornton Hlth Plan (Anthem BCBS)	NH	\$ 15,647,565	\$ (5,300,322)	\$ 182,178
42260	Time Insurance Company	NH	\$ 6,063,182	\$ 5,242,905	
51889	UnitedHealthcare Insurance Company	NH	Not Eligible		\$ 31,436
Total			\$21,811,008	Zero	Zero

Table 5: Federal Reinsurance and Risk Adjustment Payments in CY 2014 by Carrier⁶¹

8. Regional and National Comparisons

New Hampshire has high average premiums in the Individual and Small Group Markets compared to the rest of the country, but also has one of the highest median incomes and highest median age in the country.

- Based on data from CMS’s risk adjustment report, New Hampshire’s premiums rank tenth highest in the Individual Market and fourth highest in the Small Group Market for ACA compliant plans.⁶²

⁶¹ CMS, SUMMARY REPORT ON TRANSITIONAL REINSURANCE PAYMENTS AND PERMANENT RISK ADJUSTMENT TRANSFERS. FOR THE 2014 BENEFIT YEAR, Revised: September 17, 2015 <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf>

⁶² These data have not been adjusted for demographic or benefit differences by state. 2014 risk adjustment data represents a partial year as the transition to ACA compliant plans occurred on the anniversary date. It will be possible in 2015 to review a full year of ACA compliant plans and premiums and to adjust for benefits and demographic differences. Massachusetts is not included in this chart since they are the only state to have a state operated risk adjustment program.

- New Hampshire has one of the highest median incomes in the country, therefore New Hampshire’s premium as a percentage of household income is one of the lowest in the country (eighth lowest in the country).⁶³ In 2013, New Hampshire premium as a percentage of income is 18% compared to the national average of 22%.
- New Hampshire Hospital admissions per 1000 population rank twelfth lowest compared to other states. New Hampshire has 90 admissions per 1000 population compared to 106 nationally. New Hampshire has higher than average emergency room visits (529 visits per 1000 population compared to the national average of 423).⁶⁴
- New Hampshire also has a high median age compared to other states, ranking as the fourth highest in 2010.⁶⁵
- New Hampshire also ranks in the country’s top ten for physician compensation.⁶⁶
- It is difficult to directly compare prices in New Hampshire to other states, partly due to a lack of available data in other states. A preliminary review of a subset of services in New Hampshire versus Maine shows that New Hampshire has significantly higher median prices for four out of the six services studied. Additional data and analyses are needed to provide a more complete comparison of price.

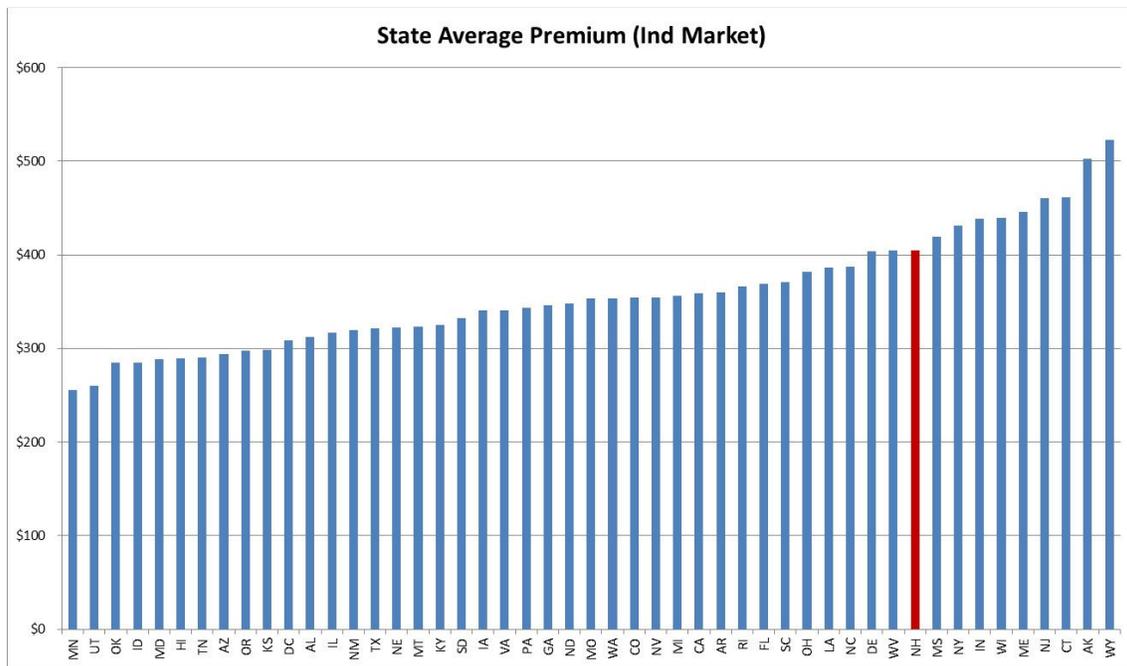


Figure 27: Individual Market Premiums by State- 2014 Benefit Year⁶⁷

⁶³ State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013. The Commonwealth Fund. Available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1798_schoen_state_trends_2003_2013.pdf

⁶⁴ The Kaiser Family Foundation State Health Facts. Data Source: 1999 - 2012 AHA Annual Survey, Copyright 2013 by Health Forum, LLC, an affiliate of the American Hospital Association; Population data from Annual Population Estimates by State, U.S. Census Bureau; available at <http://www.census.gov/popest/>.

⁶⁵ Age and Sex Composition, 2010. United States Census Bureau. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf>

⁶⁶ Medscape Physician Compensation Report 2015. Available at: <http://www.medscape.com/features/slideshow/compensation/2015/public/overview#page=7>

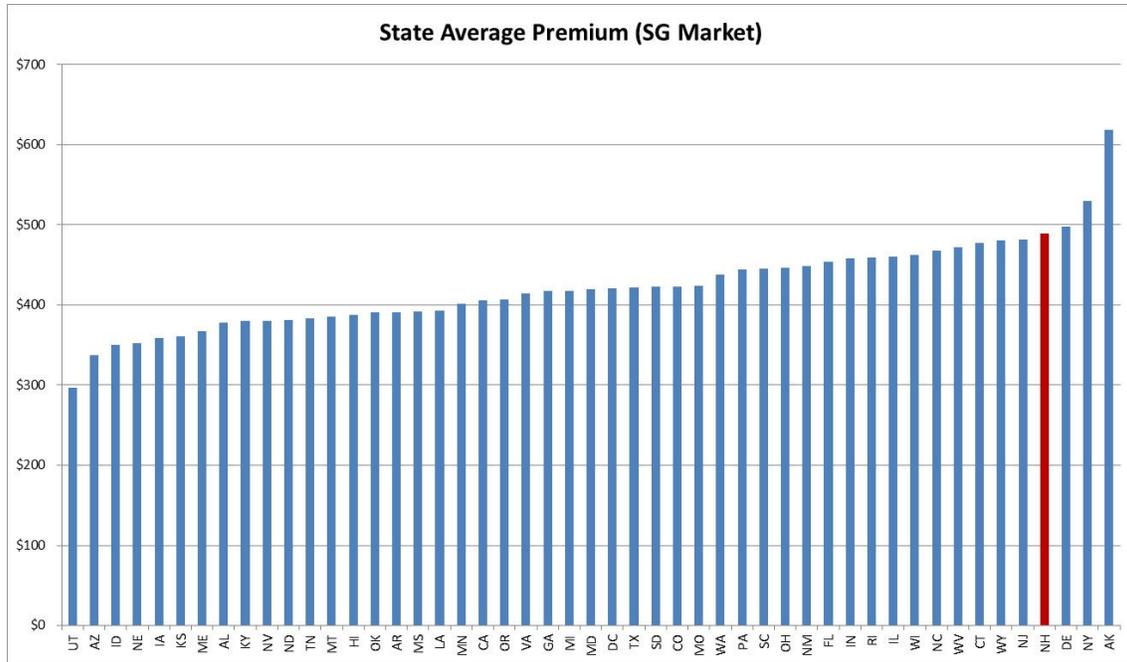


Figure 28: Small Group Market Premiums by State- 2014 Benefit Year⁶⁸

	Median Costs		
	New Hampshire	Maine	% Difference (NH vs ME)
99212 (Basic Office Visit)	\$66	\$90	-28%
99283 (ER- Medium)	\$691	\$498	39%
72148 (MRI Back)	\$1,783	\$1,223	46%
45378 (Colonoscopy)	\$2,651	\$1,964	35%
19103 (Breast Biopsy)	\$4,779	\$3,642	31%
29881 (Knee Surgery)	\$6,910	\$7,188	-4%

Table 6: Comparison of Median Prices for a Subset of Services in New Hampshire versus Maine⁶⁹

⁶⁷ Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers, Revised September 17, 2015. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf>

⁶⁸ Ibid.

⁶⁹ New Hampshire prices from NH Health Care Cost website: <http://nhhealthcost.nh.gov/insured>. Maine prices from Health Cost website: <https://mhdo.maine.gov/healthcost2014/>. Based on statewide median prices for each carrier in each product. Excluded prices in New Hampshire with low or very low precision.

9. Product Innovation

Low-cost provider benefit designs, or site of service benefit designs,⁷⁰ continue to be a popular option for many employers. Although their market penetration may have peaked at this point, opportunities may exist by expanding cost sharing incentives to other types of services.

- As of April 2015, approximately 79% of Small Group and 43% of Large Group fully-insured members are in these options. This is fairly consistent with results from the past two years.
- Market penetration of the low-cost provider options has increased in the self-insured market but also appears to have achieved a peak with approximately 11% of members as of April 2015.
- Current low-cost provider options have mainly focused on creating cost sharing incentives for ambulatory surgery and outpatient lab services, but carriers are exploring expanding these options to other services such as outpatient ultrasound, x-ray imaging, physical therapy, occupational therapy and speech therapy.
- Results will vary for specific surgeries and labs, but generally there are significant cost differences, both for total allowed costs and member costs for utilization at ambulatory surgical centers and zero cost labs versus outpatient hospital settings.
- Members both in the low-cost provider options and members not in low-cost provider options continue to shift their usages to ambulatory surgical centers, although this movement has also slowed down compared to what was observed in prior years.
- Low-cost provider options are not currently offered in the Individual Markets in New Hampshire.

CY 2014 GI Endoscopy Costs			
Members in Low-Cost Provider/Site of Service Option			
	Outpatient Hospital	Ambulatory Surgical Centers	\$ Difference
Allowed Cost per Surgery	\$2,680	\$1,364	-\$1,316
Member Cost Sharing per Surgery	\$927	\$81	-\$846

Table 7: 2014 Costs for GI Endoscopy by Site of Procedure⁷¹

⁷⁰ The benefit designs provide financial incentives to members to choose lower cost facilities specifically for outpatient surgery or laboratory services. An example of how this benefit design works is as follows: If a member has an outpatient surgery at a hospital, the deductible will first apply, and that deductible may be anywhere from \$1,000 to \$5,000. If the member has the same outpatient surgery at an ambulatory surgical center (ASC), the cost sharing is a fixed copayment amount of \$100 to \$125. In the case of a laboratory service, if the laboratory service takes place at an outpatient hospital, the deductible will first apply. If the member has the same laboratory service at an independent lab, the member pays no cost sharing.

⁷¹ NHID Annual Hearing data 2015.

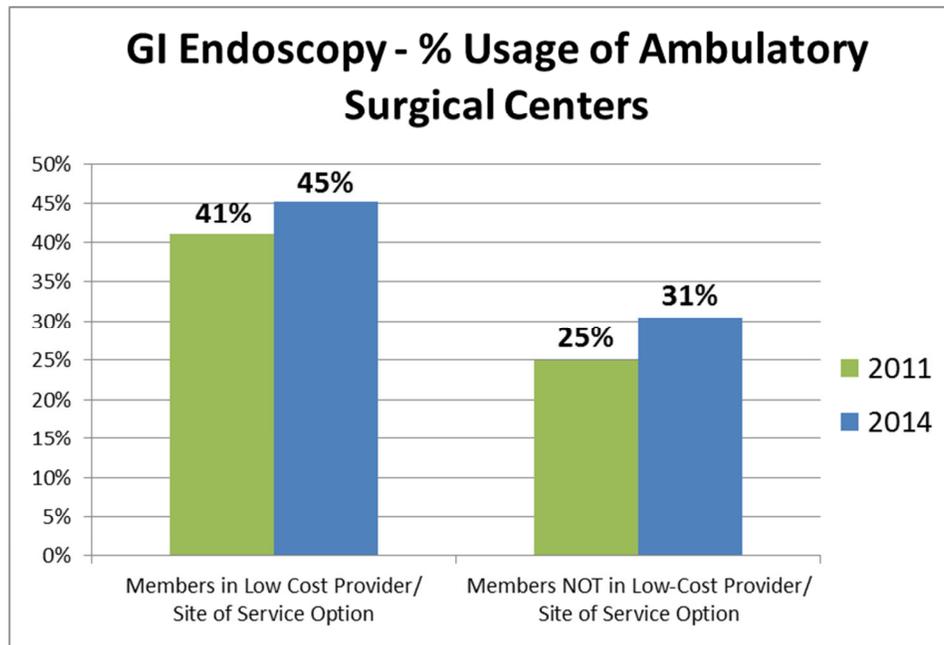


Figure 29: GI Endoscopy Percentage Usage of Ambulatory Surgical Centers⁷²

Membership in tiered network hospital products⁷³ at one point appeared to have been gaining some increasing membership, but has since declined. As of April 2015, only 2% of members are in these products in the fully-insured market. These are slightly more popular in the self-insured markets with approximately 8% of members as of April 2015.

Limited network HMO products continue to gain market share, primarily in the Individual Exchange Markets.

- Anthem (Matthew Thornton) is the only carrier on the exchange in 2014, and the only product offering on the exchange in 2014 is a limited network HMO (referred to as the Pathway Network). Harvard Pilgrim began offering a limited network HMO (referred to as the Elevate Health Network) to Small Groups and Large Groups in 2014 and as of January 1, 2015, Harvard Pilgrim joined the exchange where these products are also being sold in the Individual Market.

⁷² NHID Annual Hearing data 2013, 2014 and 2015.

⁷³ Tiered network plans typically separate a broad network of providers into one, two, or three tiers, or groupings of providers. The first tier, or Tier 1, is generally the smallest group of providers and is considered the most efficient, based on cost and quality metrics. The next level, or Tier 2, would generally include a larger grouping of providers and would be considered not as efficient as Tier 1. These products offer member cost sharing incentives when members choose services from the Tier 1 group of providers. These products are designed to encourage members to utilize services of more efficient providers, which results in lower costs and improved quality of care.

- As of December 2014, 17% of the overall fully-insured market members were in limited network HMO products driven by 100% participation in the Individual Exchange Market and 43% in the Individual Non-Exchange Market. These estimates are expected to grow into 2015.
- Limited network HMO's have gained some traction in the self-insured markets with 4% market share as of April 2015.
- Anthem stated that premiums for limited network products are approximately 30% lower compared to comparable plans with a broad network.⁷⁴ Harvard Pilgrim stated that limited network products are generally lower by double-digits compared to comparable broad network plans.⁷⁵
- Both carriers have stated that their original limited network products have expanded the hospitals and physicians included in the network in 2015. There is generally a trade-off between the size of the network and the premium savings generated for customers, where the larger the network the lower the premium savings compared to a broad network product.

10. Future Considerations

As we look into 2015 and beyond, the health care insurance landscape will continue to change. New Hampshire will be impacted by the addition of new carriers and products on the exchanges, the “Cadillac tax”⁷⁶ and Medicaid expansion. This is in addition to New Hampshire stakeholders continuing to pursue health care cost transparency, provider payment reform and product innovation as ways to further manage health care costs.

- In 2014, there was only one carrier on the Individual Market exchange (Anthem/Matthew Thornton). In 2015, there are five carriers on the exchange (Anthem/Matthew Thornton, Harvard Pilgrim Health Care, Minuteman Health, Community Health Options and Assurant/Time). In 2016, there will continue to be five carriers on the exchange, although one carrier has exited the market (Assurant/Time) and been replaced by one new carrier (Ambetter/Celtic).
- The ACA's high-cost plan tax, better known as the “Cadillac tax” comes into effect in 2018, but employers have indicated that they began to make changes to plan designs as early as 2014 in anticipation of this tax. The Kaiser Family Foundation has estimated that 26% of employers nationally would have at least one plan affected by the Cadillac tax in 2018.⁷⁷

⁷⁴ “Anthem Blue Cross and Blue Shield, Elliot Health System Reach Agreement on Pathway Network”, available at: <https://www.anthem.com/health-insurance/about-us/pressreleasedetails/NH/2015/1876/anthem-blue-cross-and-blue-shield-elliott-health-system-reach-agreement-on-pathway-network>

⁷⁵ Elevate Health plan information, available at: https://www.harvardpilgrim.org/portal/page?_pageid=849,2919992&_dad=portal

⁷⁶ Plans with annual premiums exceeding \$10,200 for individuals or \$27,500 for a family

⁷⁷ Kaiser Family Foundation: How Many Employers Could be Affected by the Cadillac Plan Tax? August 2015. Available at: <http://kff.org/health-costs/issue-brief/how-many-employers-could-be-affected-by-the-cadillac-plan-tax>

- As of January 2016, adults in New Hampshire who are newly eligible for Medicaid will enroll in exchange plans in the Individual Market, thus becoming part of the Individual Market rating pool.⁷⁸ Carriers have indicated that this change is one of the key drivers of overall rate increases in the Individual Market in 2016.⁷⁹

11. Limitations and Data Reliance

Gorman Actuarial prepared this report for the use of the New Hampshire Insurance Department. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This report should only be distributed in its entirety.

Users of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by the New Hampshire Insurance Department, carriers in the New Hampshire health insurance markets, the National Association of Insurance Commissioners (NAIC) and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of October 2015. If subsequent changes are made, these statements may not appropriately represent the expected future state.

12. Qualifications

This study includes results based on actuarial analyses conducted by Jennifer Smagula and peer reviewed by Bela Gorman, both of whom are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.

⁷⁸ Medicaid will provide premium subsidies to these newly eligible Medicaid members.

⁷⁹ <https://ratereview.healthcare.gov/>, Maine Community Health Options rate filing, et al.